Washington State Health Care Authority

REPORT TO THE LEGISLATURE

DR. ROBERT BREE COLLABORATIVE ANNUAL REPORT

Engrossed Substitute House Bill 1311; Section 3; Chapter 313; Laws of 2011

November 15, 2020

DR. ROBERT BREE COLLABORATIVE

Washington State Health Care Authority

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Acknowledgments

Thank you to our Bree Collaborative chair, Dr. Hugh Straley, and our dedicated Bree Collaborative members and many workgroup members who have donated countless hours to improve health care quality, outcomes, and affordability in Washington State.

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EXECUTIVE SUMMARY

Stakeholders working together to improve health care quality, outcomes, affordability, and equity in Washington State.

This is the ninth annual report submitted by the Health Care Authority (HCA) on behalf of the Dr. Robert Bree Collaborative (Bree Collaborative or Collaborative) to the Washington State Legislature as directed in Engrossed Substitute House Bill 1311 (ESHB 1311), Section 3, and enacted as Chapter 313, Laws of 2011. This report describes the achievements of the Bree Collaborative from November 2019 through October 2020.

HCA is the sponsoring agency of the Bree Collaborative, a public/private group created to give health care stakeholders the opportunity to improve health care quality, patient outcomes, and affordability in Washington State through recommendations regarding specific health care services.

ESHB 1311, Section 3 calls for the Bree Collaborative to:

> *"… report to the administrator of the authority regarding the health services areas it has chosen and strategies proposed. The administrator shall review the strategies recommended in the report, giving strong consideration to the direction provided in section 1, chapter 313, Laws of 2011 and this section. The administrator's review shall describe the outcomes of the review and any decisions related to adoption of the recommended strategies by state purchased health care programs. Following the administrator's review, the Bree Collaborative shall report to the legislature and the governor regarding chosen health services, proposed strategies, the results of the administrator's review, and available information related to the impact of strategies adopted in the previous three years on the cost and quality of care provided in Washington state. The initial report must be submitted by November 15, 2011, with annual reports thereafter."*

Since its 2011 formation, the Bree Collaborative has successfully pursued its mission to improve health care quality, patient outcomes, and affordability in our state. Year nine accomplishments included supporting seven active workgroups, drafting five sets of recommendations.

This year we have:

- Developed recommendations to define, standardize, and incent spending in primary care
- Developed recommendations to impact unnecessary and potentially harmful inpatient care utilization for people undergoing treatment for cancer
- Developed recommendations to improve accessibility of colorectal cancer screening
- Developed recommendations in response to legislation to improve quality, equity, and cultural appropriateness of reproductive and sexual health care services across the lifespan
- Continued to engage with the pain specialty and patient advocate community to develop patient-centered recommendations to support patients on long-term opioid therapy
- Worked with health care purchasers, health plans, provider groups, and state agencies to encourage adoption of Bree Collaborative recommendations

BACKGROUND

The American health care system continues to have worse health outcomes for higher cost than many high-income countries; including shorter life expectancy, higher chronic disease burden, and wider health disparities.[1] This gap becomes more apparent as our country works to address the pandemic caused by COVID-19. Many of the dollars spent do not add to patient health or quality of care and are considered wasted.[2,3] Over a four-year period in Washington State alone, $703 million was spent on unnecessary or low-value health care services.[4] Prices for medical services vary widely, from $7,000 to over $20,000 for a cesarean section delivery.[5] Variation in price, processes, and outcomes within health care delivery and high rates of use of specific health care services can indicate poor quality, inappropriate services, and potential waste.

Washington State has prioritized increasing the quality and affordability of health care through innovative work such as the Health Technology Assessment program, the Prescription Drug Program, Healthier Washington, and the Dr. Robert Bree Collaborative. The Bree Collaborative's work is a key part of Healthier Washington, providing evidence-based standards of care and purchasing guidelines for high-variation, high-cost health care services. The Bree Collaborative is structured after the work of the Advanced Imaging Management (AIM) project and named in memory of Dr. Robert Bree. Dr. Bree was a leader in the imaging field and a key member of the AIM project working to reduce inappropriate use of advanced imaging (e.g., CT, PET, and MRI scans) in Washington State.

ESHB 1311 OVERVIEW

The Washington State Legislature established the Bree Collaborative in 2011 to provide a process for public health care purchasers for Washington State, private health care purchasers (self-funded employers and union trusts), health plans, physicians and other health care providers, hospitals, and quality improvement organizations to work together to identify and recommend evidence-based strategies to improve health care quality, outcomes, and affordability. Engrossed Substitute House Bill 1311 (ESHB 1311) amended RCW 70.250.010 (Advanced Diagnostic Imaging Workgroup definition) and 70.250.030 (Implementation of Evidence-Based Practice Guidelines or Protocols); added a new section to Chapter 70.250 RCW; created a new section; and repealed RCW 70.250.020.

All Collaborative meetings are open to the public and follow the Open Public Meetings Act.

The Bree Collaborative is charged with annually identifying health care service areas in which there are differences in how care is delivered between clinics, facilities, or providers or higher use of care that does not cause better outcomes for patients. Collaborative staff seeks direction for which health care services to select from Bree Collaborative members, the Legislature, the Washington State Agency Medical Directors Group, state associations, other community partners, and the public.

See **Appendix A** for more detail about the Bree Collaborative's background.

The Bree Collaborative consists of the following Governor-appointed expert stakeholders:

- Two health carrier or third-party administrator representatives
- One health maintenance organization representative
- One national health carrier
- Two physician representatives from large multispecialty clinics with 50 or more physicians, one of whom is a primary care provider
- Two physician representatives from clinics with fewer than 50 physicians, one of whom is a primary care provider
- One osteopathic physician representative
- Two physician representatives from the largest hospital-based physician groups in the state
- Three hospital systems representatives, at least one of whom is responsible for quality
- Three self-funded purchaser representatives
- Two state-purchased health care programs representatives
- One Washington Health Alliance representative (previously the Puget Sound Health Alliance)

See **Appendix B** for a current list of Bree Collaborative members. See **Appendix C** for a list of steering committee members. See **Appendix D** to see a list of workgroup members for each of these topics.

SUMMARY OF RECENT WORK

In the Bree Collaborative's ninth year — November 2019 to October 2020 — the Collaborative focused on developing new evidence-based recommendations and working to foster adoption of existing recommendations.

The Bree Collaborative:

- ✓ Supported seven active workgroups
- ✓ Adopted five recommendations
- ✓ Received HCA approval on one recommendation

The Bree Collaborative formed workgroups to develop recommendations for primary care, colorectal cancer screening, oncology treatment and inpatient care use, reproductive and sexual health, and finalized recommendations for long-term opioid therapy. These workgroups are profiled on the following pages. See **Appendix E** for a summary of work from 2011 – 2018.

The Bree Collaborative approved and submitted the following recommendations to the HCA:

- **Palliative Care Report and Recommendations**
  (Adopted November 2019)
  - www.breecollaborative.org/wp-content/uploads/Palliative-Care-recommendations-FINAL-2019.pdf
- **Shared Decision-Making Report and Recommendations**
  (Adopted November 2019)
  - www.breecollaborative.org/wp-content/uploads/Recommendations-Shared-Decision-Making-FINAL-2019.pdf
- **Maternity Bundled Payment Model**
  (Adopted January 2020)
  - www.breecollaborative.org/wp-content/uploads/Maternity-Bundle-FINAL-2020.pdf
- **Risk of Violence to Others Report and Recommendations**
  (Adopted January 2020)
  - www.breecollaborative.org/wp-content/uploads/Recommendations-Risk-Violence-Others-FINAL-2020.pdf
- **Long-Term Opioid Therapy Report and Recommendations**
  (Adopted May 2020)
  - www.breecollaborative.org/wp-content/uploads/Bree-Long-Term-Opioid-Use-Recommendations-FINAL-20-05.pdf

At the July meeting, Bree Collaborative members selected four new topics for 2021 including:

- Cervical cancer screening
- Opioids in the elderly
- Telehealth
- Total joint bundle re-review

COLORECTAL CANCER SCREENING

The workgroup has been meeting monthly since January 2020 and continues to develop these recommendations.

Learn more about the workgroup and see all past meeting materials:
www.breecollaborative.org/topic-areas/current-topics/colorectal-cancer/

BACKGROUND

Colorectal cancer is common, being the fourth most commonly diagnosed cancer in the United States, after lung, prostate, and breast cancers.[6] Approximately 4.2% of people are diagnosed at some point in their lifetime. However, colon cancer is the second leading cause of cancer death in the United States, following lung cancer, showing the need for better interventions to increase screening. Survival rates vary based on the stage of cancer at diagnosis, but also by race with black Americans having a 9-10% net lower survival at five years than white Americans.[7]

Colorectal cancer screening decreases both the incidence of and mortality from colorectal cancer due to finding cancer in earlier stages where cancer is not widespread and through finding and removing precancerous lesions through direct visualization tests.[8] Nationally, the Medicare colorectal cancer screening rate is 73%. In Washington State, of adults aged 50 to 75 years, only 63% with commercial insurance and 43% of Medicaid recipients received screening, with significant variation county by county.[9] Death from colorectal cancer occurs when screening does not occur, when screening does not occur at the appropriate interval(s), when screening is inaccurate or fails, when surveillance following the identification of an adenoma fails, or when follow-up from a positive screen does not occur.[10]

Barriers to these interventions include capacity within health care delivery systems for initiatives, higher cost for initiatives that need dedicated resources, lack of time in the clinical visit, and assuring follow-up for positive tests.[4] Further, stigma around the colorectal system and fecal matter, the difficulties in preparing for a colonoscopy, and issues with copays being present if a colonoscopy is indicated after a positive fecal test serve as significant barriers.[11]

OUR WORK

The workgroup's goal is to increase appropriate colorectal cancer screening in Washington State in order to decrease incidence of and mortality from colorectal cancer. Focus areas are designed to address the barriers to comprehensive screening including tracking, measurement, patient-centered care, and payment. The workgroup promotes the idea that the best test is the one that gets done, acknowledging a patient preference for the annual fecal test over the more invasive colonoscopy.

ONCOLOGY CARE

The workgroup has been meeting monthly since January 2020 and continues to develop these recommendations.

Learn more about the workgroup and see all past meeting materials:
www.breecollaborative.org/topic-areas/current-topics/oncology-care-inpatient/

BACKGROUND

Every year an estimated 1.7 million new cases of cancer will be diagnosed with an incidence of 439.2 per 100,000 people.[12] Incidence and mortality rates show disparities based on race and ethnicity as well as socioeconomic status. Black Americans show higher mortality rates and those living in more socially disadvantaged areas show higher cancer incidence and mortality.[13]

Treatment for cancer is either localized, such as with surgery and radiation therapy, or introduced through the bloodstream and therefore systemic, such as with chemotherapy or immunotherapy.[4] Goals of treatment include both improved quality of life and to prolong life. However, cancer treatment can cause a wide variety of side effects from hair loss to pain, nausea, and a decrease in white blood cells leading to infections.[14]

While the majority of oncology care is planned and provided through out- or in-patient services, patients also frequently seek treatment for urgent and emergent issues, often from side effects of treatment, through emergency departments, indicating an opportunity for better symptom management throughout the disease course.[15] Studies show that people with bladder, ovarian and liver cancer have higher acute care admissions when compared to other cancer types.[11] Having other comorbidities or diagnoses alongside the cancer diagnosis, being of advanced age, having more advanced or widespread disease, and having a longer initial stay in the hospital are significant predictors of using inpatient care.[16] Patients most commonly present to the emergency department with pain, fatigue, dyspnea, fever, and gastrointestinal problems.[17]

OUR WORK

The workgroup's goal is to reduce potentially avoidable emergency department visits and therefore improve patient experience and care outcomes for patients undergoing cancer treatment. Systematic reviews show five strategies for reducing unplanned acute care use among oncology patients including: identifying patients at high risk for unplanned acute care, enhancing access and care coordination, standardizing clinical pathways for symptom management, developing new loci for urgent cancer care, and using early palliative care.[18] The four focus areas include assessment and risk stratification, patient-centered care (e.g., goals of care, education), case management (e.g., outreach), and integrating palliative care alongside life-prolonging and/or curative care.

PRIMARY CARE

The workgroup has been meeting monthly since January 2020 and continues to develop these recommendations.

Learn more about the workgroup and see all past meeting materials:
www.breecollaborative.org/topic-areas/current-topics/primary-care/

BACKGROUND

Primary care, widely identified as the cornerstone of the health care system, serves as a usual source of care focused on both acute and chronic disease detection, management, treatment, and prevention.[19] Efforts to define primary care often start with a broad scope of services and general attributes and are often described in contrast to health care services provided for acute or urgent needs or within a hospital or surgical setting.

Studies consistently find an association between a higher ratio of primary care physicians at a state-level and population-level health outcomes such as lower all-cause mortality and mortality from heart disease, cancer, stroke, as well as infant mortality.[20] Presence of primary care providers is also associated with increased life span, reduction in infant low birth weight, better overall patient experience, and a person's self-rated health.[21,22,23]

OUR WORK

In many studies, primary care is defined by four Cs:

- First-contact care
- Comprehensive in addressing a wide variety of issues from sprains to behavioral health to prenatal care
- Continuous with multiple touch-points over time
- Coordinated

In order to know whether primary care spend is increasing in the state, Washington must first develop an agreed upon definition of primary care that will allow for accurate measurement.

The workgroup's goal is to foster a common understanding of primary care in order to increase primary care accessibility and availability using and expanding the four Cs to include: accountability including advanced clinical judgement, team based including behavioral health, first contact, comprehensive, continuous, coordinated, and appropriate. This definition will be used to inform other Washington State areas of primary care focus.

REPRODUCTIVE AND SEXUAL HEALTH

The workgroup has been meeting monthly since January 2020 and continues to develop these recommendations.

Learn more about the workgroup and see all past meeting materials:
www.breecollaborative.org/topic-areas/current-topics/reproductive-health/

BACKGROUND

The World Health Organization defines reproductive health as "*a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes…imply[ing] that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so*."[24] Reproductive and sexual health services are broad and include screening and treatment for sexually transmitted infections, screening and treatment of disorders of the genital organs (e.g., cancer, fibroids, endometriosis), and family planning including contraception, infertility treatment, pre-conception care, prenatal care, labor and delivery, and postpartum care. Further, reproductive and sexual health services can serve as an entry point into the health care system, helping to decrease disparities in access to care and potentially outcomes broadly.

Health disparities, preventable differences in health outcomes, are due to a multitude of intersecting factors including problematic interpersonal interactions and systematic inequality. The impact of shared social experiences such as slavery and segregation impact differences in health outcomes and access to resources (e.g., redlining) that in turn impact health outcomes.

OUR WORK

The Bree Collaborative was asked through Senate Bill 5602 (2019) to develop a workgroup to "identify, define, and endorse guidelines for the provision of high quality sexual and reproductive health services in clinical settings throughout Washington…include[ing] the development of specific clinical recommendations to improve sexual and reproductive health care for: (a) People of color; (b) Immigrants and refugees; (c) Victims and survivors of violence; and (d) People with disabilities."

The workgroup recommends system- and individual-level changes to build a health care system that truly meets the needs of a diverse population. Differences in population disease burden, needs, and resilience necessitate different clinical services and care, and the workgroup seeks to base changes in a targeted universalism approach, universal goals pursued by targeted interventions.[25] Focus areas include cultural humility including care free of coercion or bias, access to care including understanding barriers to insurance of a population, patient-centered care including trauma-informed care, and appropriate care based on available evidence.

IMPLEMENTATION

HCA champions Bree Collaborative recommendations, which also are supported and spread by Bree Collaborative member organizations and many other community organizations. Moving from a fee-for-service to a value-based reimbursement structure has been a key part of the HCA's focus. The Bree Collaborative also engages with many diverse stakeholders to move toward adoption of the recommendations. In 2019, the Bree Collaborative received additional funds from the Legislature to conduct targeted implementation efforts and has thus far focused on augmenting primary care through integration of behavioral health. See **Appendix F** for information on the 2016 implementation survey and roadmap.

PAYING FOR VALUE

In alignment with Washington State's goal to move health care payment from volume to value and deliver more coordinated, whole person care, HCA includes Bree Collaborative recommendations in the two Public Employees Benefits Board (PEBB) Program accountable care network options: Uniform Medical Plan (UMP) Plus—Puget Sound High Value Network, led by Virginia Mason Medical Center, and UMP Plus—University of Washington (UW) Medicine Accountable Care Network. Both networks have met the contractual obligation to submit quality improvement plans for obstetrics, total knee and total hip replacement, lumbar fusion, care coordination for high-risk patients, hospital readmissions, cardiology, low back pain, end-of-life care, and addiction and dependence treatment.

Continuing the emphasis on paying for value, HCA designated Virginia Mason Medical Center as the center of excellence for total joint replacement surgery using the Bree Collaborative's total knee and hip replacement bundled payment as a model. Since January 2017, enrollees in the PEBB Program's Uniform Medical Plan Classic or UMP Consumer-Directed Health Plan who select Virginia Mason for this procedure pay no coinsurance (with the exception of UMP CDHP members who are required by IRS rules to meet their deductible first). Premera Blue Cross administers the centers of excellence program. As of January 2019, 166 surgeries have been completed with no reported complications, high member satisfaction, and an overwhelming majority of referrals meeting appropriateness criteria. In May 2019, Premera Blue Cross announced a new contract with Providence St. Joseph Health naming seven facilities as centers of excellence for total joint replacement following the Bree Collaborative guidelines. As of January 2019, HCA has contracted with two centers of excellence for spine care and surgery, Capitol Medical Center and Virginia Mason Medical Center

COMMUNITY ENGAGEMENT

Collaborative implementation activities focus on education, consensus-building, outreach, and engagement including:

- Outreach to community associations including the Washington State Hospital Association (WSHA), the Washington State Medical Association (WSMA), the Washington Health Alliance, the Washington State Public Health Association, and Washington Patient Safety Coalition

- Speaking at in-person and virtual events including University of Washington School of Public Health, American Cancer Society meeting, Accountable Community of Health meetings, and Performance Measures Coordinating Committee
- Increasing Collaborative visibility through the website (www.breecollaborative.org), maintaining a blog with monthly or bi-monthly posts highlighting Collaborative topics or implementation strategies, and using social media to engage the community

Many dedicated community organizations have also contributed to the implementation of Bree Collaborative recommendations:

- *Addiction Screening*: The two HCA Accountable Care Programs; the Puget Sound High Value Network, led by Virginia Mason Medical Center; and the UW Medicine Accountable Care Network routinely train and utilize the Screening, Brief Intervention, and Referral to Treatment model and have integrated a tool to screen for alcohol use into electronic medical records and workflow.
- *Behavioral Health Integration*: HCA used Bree Collaborative standards for integrating behavioral health into primary care to inform the development of required Accountable Communities of Health projects under the Medicaid Transformation Project.
- *Cardiology*: The Clinical Outcomes Assessment Program (COAP) continues to monitor insufficient information around percutaneous coronary intervention.
- *End-of-Life Care*: WSHA and WSMA are still actively spreading advance care planning at the health system and community levels, aligned with the recommendations. The two associations are working to promote patient-centered end-of-life conversations through Honoring Choices®: Pacific Northwest.
- *Spine Surgery:* Spine Clinical Outcomes Assessment Program (SCOAP) has 18 hospitals enrolled. As of August 2014, length of stay, radiologic verification of surgical level, and smoking use have been available on the website.
- *Obstetrics*: Both the Obstetrics Clinical Outcomes Assessment Program (OB-COAP) and WSHA's Safe Deliveries Roadmap have aligned existing program expectations and data collection with Bree Collaborative recommendations for member hospitals.
- *Oncology*: Collaborative staff have participated in the Hutchinson Center for Cancer Outcomes Research Value in Cancer Care workgroup.
- *Opioid Prescribing*: All metrics are being used by the Washington State Department of Health to track opioid prescribing. Three metrics (new opioid patients transitioning to chronic opioids, patients prescribed high-dose chronic opioid therapy, new opioid patients' days' supply of first opioid prescription) have been adopted and will be included in the state Common Measure Set (i.e., a statewide set of measures that is part of Healthier Washington meant to increase health care accountability and performance) by the Performance Measures Coordinating Committee.

TARGETED IMPLEMENTATION

The 2019-2021 implementation project will focus on behavioral health integration and value-based payment with the option of being responsive to additional community asks. Behavioral health has broad community engagement, multiple stakeholders involved, and there are ready experts in Washington State. Value-based payment, and specifically the four surgical bundled payment models, has seen the Health Care Authority act as a first mover followed by Premera, Washington's largest health plan, adopting a similar center of excellence contracting model. Further, this implementation effort will dovetail with the provision of Cascade Care, the Washington State public option.

This implementation work will have five focus areas including: 1:1 practice coaching to a primary care practice pilot group to integrate behavioral health, a broader, regionally-based behavioral health integration learning community, engagement with health plans to support behavioral health integration and value-based payment, assessment of delivery systems and health plans for all 23 sets of recommendations, and creation of a learning community for value-based payment.

Bree Collaborative staff engaged with 10 primary care clinics throughout Washington State and began discussions with additional clinics in January and February, 2020. Each clinic developed a six-month action plan of three to four quality improvement projects based on identified gaps within their assessment. Bree Collaborative staff worked with the primary care pilot group to complete the Maine Health Access Foundation (MeHAF) Assessment and a Bree Collaborative Behavioral Health Integration Assessment in January and February, 2020. Each clinic identified an internal team to complete these assessments and develop a six-month action plan of three to four quality improvement projects based on identified gaps within their assessments. Each team consisted of a variety of staff roles (e.g. Provider, Medical Assistant, Nurse, Administrative, IT, Front Desk) in order to provide a wide range of perspectives related to the patient experience.

Clinics include:

- Aberdeen Family Medical Clinic – Harbor Medical Group
- Bremerton – Kitsap Medical Group
- Brewster Jay Avenue Clinic – Family Health Centers
- Community Health Centers of Snohomish County
- Family Care of Kent – Health Management Services Organization
- Nisqually Tribal Health Clinic
- Pullman Family Medicine
- Seattle Children's Clinic at Harborview
- Seattle Children's Hospital Odessa Brown Children's Clinic
- Shoreline – International Community Health Services
- Snoqualmie Ridge Medical Clinic

Bree Collaborative staff have hosted monthly webinars, with the exception of March 2020, starting in January and aligned with the behavioral health recommendations. All webinars featured community partners talking through overcoming barriers to implementation and overall strategy

as well as an overview of the Bree Collaborative recommendations and available resources to drive implementation. All recordings are available on the Bree Collaborative YouTube channel.

Webinars included:

- **January 29 Behavioral Health Integration - 183 Attendees**
  Link to recording: www.youtube.com/watch?v=1LNtmfgzXEI

  Overview of integrating behavioral health into primary care featuring the AIMS Center and the Yakima Valley Farm Workers Clinic with Sara Barker, MPH, Assistant Director for Implementation at the University of Washington AIMS Center and Phillip Hawley, PsyD, Primary Care Behavioral Health Director, Yakima Valley Farm Workers Clinic (YVFWC).

- **February 26 Suicide Care - 88 Attendees**
  Link to recording: www.youtube.com/watch?v=CznmuLN533M

  Overview of screening for and intervening around suicidality featuring Jeffrey Sung, MD, acting instructor, University of Washington Department of Psychiatry and Behavioral Sciences and Kate Comtois, PhD, MPH, Professor, Department of Psychiatry and Behavioral Sciences; Adjunct Professor, Department of Psychology at the University of Washington, Co-Director, Harborview Psychotherapy Clinic.

- **April 22 Addiction and Dependence - 74 Attendees**
  Link to recording: www.youtube.com/watch?v=Vm82WpXpiAY

  Overview of the screening, brief intervention, and referral to treatment protocol featuring Jennifer Wyatt, LMHC, MAC, SUDP, King County Behavioral Health and Recovery Division; Amy Decker, MSW, LICSW, licensed independent clinical social worker; Sunny Lovin, LICSW, Senior Clinic Manager, Harborview Medical Center's Outpatient Behavioral Health Department; Lisa Pepperdine, MSN, ARNP, Planned Parenthood of the Great Northwest and Hawaiian Islands.

- **May 27 Opioid Use Disorder Treatment - 84 Attendees**
  Link to recording: www.youtube.com/watch?v=pyuTMfAL4ug

  Overview of treating opioid use disorder in a primary care setting featuring Malcolm Butler, MD, Medical Director, Columbia Valley Community Health; and Addy Adwell, RN, opioid use disorder nurse care manager, Adult Medicine Clinic, Harborview Medical Center.

- **June 24 Motivational Interviewing in SBIRT - 79 Attendees**
  Link to recording: www.youtube.com/watch?v=Xlp8XS5YCW0&t=2s

A deep dive into the motivational interviewing component of the screening, brief intervention, and referral to treatment protocol featuring Denna Vandersloot, MSW, co-director, Northwest Addiction Technology Transfer Center at the University of Washington; and David Jefferson, MSW, Director, Training and TA for Northwest ATTC.

- **August 19 Clinician Wellness & Endurance Strategies in the COVID-19 Era – 141 Attendees**
  Link to recording: www.youtube.com/watch?v=EvhQ2RJDkJk

  A conversation with leadership and clinicians around the state on supporting the behavioral needs among front line physical and behavioral health staff featuring Wendy Sisk, LMHC, Chief Executive Officer of Peninsula Behavioral Health; Tony Butruille, MD, Cascade Medical; and Trevor Covington, WA Department of Health Behavioral Health Response Team.

- **August 26 Addressing Alzheimer's Disease & Other Dementias in Washington State – 87 Attendees**
  Link to recording: www.youtube.com/watch?v=Y6jRtRzbKGU

  An overview of the Alzheimer's Disease and other Dementias recommendations including how to screen and how to access services to augment clinical judgement featuring Dr. Kristoffer Rhoads, Associate Professor in the Department of Neurology, University of Washington School of Medicine; Lynne Korte, MPH, Aging and Long-Term Policy Manager, Department of Social and Health Services, Aging and Long Term Support Division; and Jamie Teuteberg, MS, Life Stages Project Manager, Clinical Quality and Care Transformations, Washington State Health Care Authority.

- **September 15 Office Hours**

- **September 24 Partnering with Schools in Youth Suicide Prevention**

  In honor of September being suicide prevention month, the Bree Collaborative in partnership with Highline Public School Mental Health Program to discussed youth suicide prevention featuring Rachel Madding, MS, School Mental Health Program Manager, Highline Public Schools and Sophie De Haan, LMHCA, MHP, Behavioral Health Systems Navigator, Highline School District.

- **September 30 Implicit Bias and Racial Inequities in Health Care**

  A conversation about the role implicit bias has in healthcare and how it contributes to health disparities featuring Janice Sabin, PhD, Research Associate Professor, Department of Biomedical Informatics and Medical Education, University of Washington School of Medicine, and Andrea Hartzler, PhD, Associate Professor, Co-Director of Clinical Informatics and Patient-Centered Technologies (CIPCT), University of Washington School of Medicine.

- October 21 Patient Advocacy

- November 4 A place for Value in Behavioral Health

The Bree Collaborative held a virtual summit over two days on June 16 and June 23. The summit brought together over 200 partners from across the health care landscape to learn about trauma informed care, innovative telehealth strategies for the COVID-19 era, suicide care and opioid use disorder treatment, among other behavioral health topics. Our community also engaged in some thoughtful action planning on how to implement change within their organizations related to behavioral health integration. Attendees ranged from providers to policy makers to purchasers.

A second summit focused on value-based payment was held on November 12. The summit featured Dr. Don Berwick as a keynote speaker with the goal of moving the health care system from volume to value.

LOOKING FORWARD TO YEAR TEN

The Bree Collaborative received funding to focus on implementation through June 2021 and looks forward to continuing work to support the pilot group, growing the learning community, and broadening to include value-based payment. Bree Collaborative recommendations have had a direct impact on HCA's purchasing strategies, influencing the Accountable Care Networks contract, the center of excellence for total knee and total hip replacement bundled payment model, and for lumbar fusion and have helped inform contracting for private health plans.

Bree Collaborative staff looks forward to receiving feedback about recommendations from the Accountable Care Networks, Centers of Excellence, and others and revising the guidelines as necessary. Staff will continue to work with additional interested stakeholders to further adoption of the recommendations.

The active workgroups will continue to meet and will present recommendations to the Bree Collaborative in fall 2020. New workgroups will convene in early 2021 to develop recommendations.

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APPENDIX A: BREE COLLABORATIVE BACKGROUND

The Bree Collaborative has had great success working with many Washington State organizations to solicit nominations of experienced and engaged community leaders as Bree Collaborative members. In August 2011, the WSHA, the Washington State Medical Association (WSMA), the Association of Washington Healthcare Plans (AWHP), large employers, and other community stakeholders nominated health care experts who served as the Bree Collaborative's first 23 members after appointment by former Governor Chris Gregoire.

Steve Hill served as the Bree Collaborative's first Chair. Mr. Hill is the former director of the Washington State Department of Retirement Systems and former director of the HCA. In November 2014 Mr. Hill announced his retirement as Chair of the Bree Collaborative, and in March 2015 Governor Jay Inslee appointed Dr. Hugh Straley as chair. Dr. Straley is board certified in both internal medicine and medical oncology and served in many leadership roles at Group Health Cooperative. He retired as medical director and president of Group Health Physicians in 2008. He has also served as chief medical officer for Soundpath Health and as interim medical director and consultant to Amerigroup Washington.

A steering committee advises the chair. The committee is comprised of Bree Collaborative members representing a health care purchaser, health plan, health care system, and quality improvement organization.

The Bree Collaborative is housed in the Foundation for Health Care Quality. The Foundation provides project management and is responsible for employing staff. Funding from the HCA is secure through June 2020 as part of the state's budget process through a four-year grant.

The Bree Collaborative has held meetings since 2011. Meetings are Find agendas and materials for all Collaborative meetings on the Bree Collaborative website: www.breecollaborative.org. All Collaborative meetings are open to the public and follow the Open Public Meetings Act.

At the November 2012 meeting, the Bree Collaborative adopted bylaws setting policies and procedures governing the Bree Collaborative beyond the mandates established by the legislation (ESHB 1311). The Collaborative revised bylaws in September 2014.

Find current bylaws at: www.breecollaborative.org/wp-content/uploads/bylaws-final.pdf

After the Bree Collaborative identifies a focus area, it must identify and analyze evidence-based best practices to improve quality and reduce variation in practice patterns. The Bree Collaborative must also identify data collection and reporting sources and methods to establish baseline utilization rates and measure the impact of strategies reviewed by the Collaborative. To the extent possible, the Bree Collaborative must minimize cost and administrative burden of reporting and use existing data resources.

The Bree Collaborative must also identify strategies to increase the use of evidence-based practices. Strategies may include:

- Goals for appropriate utilization rates
- Peer-to-peer consultation
- Provider feedback reports

- Use of patient decision aids
- Incentives for the appropriate use of health services
- Centers of Excellence or other provider qualification standards
- Quality improvement systems
- Service utilization or outcome reporting

The Governor must appoint the Collaborative chair, and the HCA must convene the Collaborative. The Bree Collaborative must add members or establish clinical committees, as needed, to acquire clinical expertise in specific health care service areas under review. Each clinical committee shall include at least two members of the specialty or subspecialty society most experienced with the health service identified for review.

ESHB 1311, Section 3 calls for the Bree Collaborative to:

"… report to the administrator of the authority regarding the health services areas it has chosen and strategies proposed. The administrator shall review the strategies recommended in the report, giving strong consideration to the direction provided in section 1, chapter 313, Laws of 2011 and this section. The administrator's review shall describe the outcomes of the review and any decisions related to adoption of the recommended strategies by state purchased health care programs. Following the administrator's review, the Bree Collaborative shall report to the legislature and the governor regarding chosen health services, proposed strategies, the results of the administrator's review, and available information related to the impact of strategies adopted in the previous three years on the cost and quality of care provided in Washington State."

APPENDIX B: BREE COLLABORATIVE MEMBERS

Member	Title	Organization
1. Susie Dade, MS	Deputy Director	Washington Health Alliance
2. Peter Dunbar, MB, ChB, MBA (Vice-Chair)	CEO	Foundation for Health Care Quality
3. Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
4. Stuart Freed, MD	Chief Medical Officer	Confluence Health
5. Richard Goss, MD	Medical Director	Harborview Medical Center, University of Washington
6. Wm. Richard Ludwig, MD	Chief Medical Officer, Accountable Care Organization	Providence Health and Services
7. Greg Marchand	Director, Benefits & Policy and Strategy	The Boeing Company
8. Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
9. Kimberly Moore, MD	Associate Chief Medical Officer	Franciscan Health System
10. Carl Olden, MD	Family Physician	Pacific Crest Family Medicine, Yakima
11. Drew Oliveira, MD	Executive Medical Director	Regence BlueShield
12. Mary Kay O'Neill, MD, MBA	Partner	Mercer
13. John Robinson, MD, SM	Chief Medical Officer	First Choice Health
14. Jeanne Rupert, DO, PhD	Provider	One Medical
15. Angela Sparks, MD	Medical Director Clinical Knowledge Development and Support	Kaiser Permanente Washington

Member	Title	Organization
16. Hugh Straley, MD (Chair)	Retired	Medical Director, Group Health Cooperative; President, Group Health Physicians
17. Shawn West, MD	Medical Director	Premera BlueCross
18. Laura Kate Zaichkin, MPH	Director of Health Plan Performance and Strategy	SEIU 775 Benefits Group
19. Judy Zerzan, MD, MPH	Chief Medical Officer	Washington State Health Care Authority

APPENDIX C: STEERING COMMITTEE MEMBERS

Member	Title	Organization
1. Peter Dunbar, MD, ChB, MBA	CEO	Foundation for Health Care Quality
2. Stuart Freed, MD	Chief Medical Officer	Confluence Health
3. Greg Marchand	Director, Benefits and Policy and Strategy	The Boeing Company
4. Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
5. Drew Oliveira, MD	Executive Medical Director	Regence BlueShield
6. Mary Kay O'Neill, MD, MBA	Partner	Mercer

APPENDIX D: WORKGROUP MEMBERS

ACCOUNTABLE PAYMENT MODELS: LUMBAR FUSION RE-REVIEW

Member	Title	Organization
1. Lydia Bartholomew, MD	Senior Medical Director, Pacific Northwest	Aetna
2. Jonathan Carlson, MD, PhD	Neurosurgeon	Inland Neurosurgery & Spine Associates
3. Arman Dagal, MD	Medical Director	Spine SCOAP
4. Farrokh Farrokhi, MD	Neurosurgeon	Virginia Mason Medical Center
5. Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
6. Mark Freeborn, MD	Neurosurgeon	
7. Andrew Friedman, MD	Physical Medicine and Rehabilitation	Virginia Mason Medical Center
8. Michael Hatzakis, MD	Physiatrist	Overlake Medical Center
9. Sara Groves-Rupp	Asst. Administrator, Performance Improvement	University of Washington Medicine
10. Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
11. Kerry Schaefer, MS (Co-Chair)	Strategic Planner for Employee Health	King County
12. Marcia Peterson	Manager of Benefits Strategy and Design	Washington State Health Care Authority

ACCOUNTABLE PAYMENT MODELS: TOTAL KNEE AND TOTAL HIP REPLACEMENT RE-REVIEW

Member	Title	Organization
1. Lydia Bartholomew, MD	Senior Medical Director, Pacific Northwest	Aetna
2. Todd Bate	Administrator, Orthopaedics & Sports Medicine Service Line	MultiCare
3. Shawn Boice, RN, BSN, MHA	Nurse Navigator, MSK Administration	Evergreen Health Care
4. Greg Brown, MD, PhD	Orthopedic Surgeon	CHI Franciscan
5. Sharon Eloranta, MD	Medical Director, Quality and Safety Initiatives	Qualis Health
6. Andrew Friedman, MD	Physiatrist	Virginia Mason Medical Center
7. Mike Glenn	CEO	Jefferson Healthcare, Pt. Townsend
8. Kevin Macdonald, MD	Orthopedic Oncology, Adult Reconstruction	Virginia Mason Medical Center
9. Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
10. Linda Radach	Patient Advocate	
11. Kerry Schaefer, MS (Co-Chair)	Strategic Planner for Employee Health	King County
12. Jacqui Sinatra, MPA, FACHE	Service Line Director of Sports, Spine, & Ortho Health Svc	University of Washington Medical Center
13. Gaelon Spradley	Chief of Clinic Operations	Mason General Hospital
14. Theresa Sullivan	CEO	Samaritan Healthcare, Moses Lake

ACCOUNTABLE PAYMENT MODELS: BARIATRIC SURGERY WORKGROUP MEMBERS

Member	Title	Organization
1. David Arterburn, MD, MPH	Physician, Internal Medicine Group Health Research Institute Senior Investigator	Group Health Cooperative
2. Sharon Eloranta, MD	Medical Director, Quality and Safety Initiatives	Qualis Health
3. Kristin Helton, PhD	Consumer	
4. Jeff Hooper, MD	Medical Director, Weight Loss Program	MultiCare Health System
5. Dan Kent, MD	Chief Medical Officer	United Health Care
6. Saurabh Khandelwal, MD	Bariatric Surgeon	University of Washington
7. Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
8. Robert Michaelson, MD, PhD, FACS, FASMBS	President	Washington State Chapter, American Society for Metabolic and Bariatric Surgery
9. Thien Nguyen, MD	Bariatric Program Medical Director	Overlake Medical Center
10. Tom Richards	Consumer	
11. Kerry Schaefer, MS (Co-Chair)	Strategic Planner for Employee Health	King County
12. Jonathan Stoehr, MD/ Jeff Hunter, MD	Endocrinologist/ Bariatric Surgeon	Virginia Mason Medical Center
13. Brian Sung, MD	Bariatric Surgery Director	Swedish Medical Center

Member	Title	Organization
14. Tina Turner	Senior Internal Consultant	Premera Blue Cross
15. Richard Thirlby, MD	Medical Director	Surgical Care and Outcomes Assessment Program (SCOAP)

ACCOUNTABLE PAYMENT MODELS: CORONARY ARTERY BYPASS SURGERY

Member	Title	Organization
1. Drew Baldwin, MD, FACC	Cardiologist	Virginia Mason Medical Center
2. Glenn Barnhart, MD	Cardiac Surgeon	Swedish Medical Center
3. Marissa Brooks	Director of Health Improvement Programs	SEUI Healthcare Northwest Benefits
4. Susie Dade, MS	Deputy Director	Washington Health Alliance
5. Gregory Eberhart, MD, FACC	Medical Director, Cardiology	CHI Franciscan Health
6. Theresa Helle	Manager of Health Care Quality and Efficiency Initiatives	The Boeing Company
7. Bob Herr, MD	Physician	US HealthWorks
8. Jeff Hummel, MD	Medical Director, Health Care Informatics	Qualis Health
9. Dan Kent, MD	Medical Director, Quality & Medical Management	Premera Blue Cross
10. Robert Mecklenburg, MD (Co-Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
11. Vinay Malhotra, MD	Cardiologist	Cardiac Study Center
12. Kerry Schaefer, (Co-Chair)	Strategic Planner for Employee Health	King County
13. Gregg Shibata	Manager, Accountable Health Implementation	Regence Blue Shield

Member	Title	Organization
14. Shilpen Patel, MD, FACRO	Medical Director	Clinical Outcomes Assessment Program
15. Thomas Richards	Managing Director, Employee Benefits	Alaska Airlines

ACCOUNTABLE PAYMENT MODELS: LUMBAR FUSION

Member	Title	Organization
1. Susie Dade, MS	Deputy Director	Washington Health Alliance
2. Gary Franklin, MD, MPH	Medical Director	Washington State Department of Labor and Industries
3. April Gibson	Administrator	Puget Sound Orthopaedics
4. Dan Kent, MD	Medical Director, Quality & Medical Management	Premera Blue Cross
5. Bob Manley, MD	Surgeon	Regence Blue Shield
6. Gary McLaughlin	Vice President of Finance, Chief Financial Officer	Overlake Hospital
7. Robert Mecklenburg, MD (Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
8. Peter Nora, MD	Chief of Neurological Surgery	Swedish Medical Center
9. Charissa Raynor	Executive Director	SEIU Healthcare NW Benefits
10. Kerry Schaefer, MS	Strategic Planner for Employee Health	King County
11. Julie Sylvester	Vice President of Quality and Safety Initiatives	Qualis Health
12. Jay Tihinen	Assistant Vice President Benefits	Costco Wholesale

ACCOUNTABLE PAYMENT MODELS: TOTAL KNEE AND TOTAL HIP REPLACEMENT

Member	Title	Organization
1. Susie Dade, MS	Deputy Director	Washington Health Alliance
2. Joe Gifford, MD	Chief Strategy and Innovation Officer for Western Washington	Providence Health and Services
3. Bob Herr, MD	Medical Director, Government Programs	Regence Blue Shield
4. Tom Hutchinson	Practice Administrator	PeaceHealth
5. Rich Maturi	Senior Vice President, Health Care Delivery Systems	Premera Blue Cross
6. Gary McLaughlin	Vice President of Finance	Overlake Hospital
7. Robert Mecklenburg, MD (Chair)	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
8. Kerry Schaefer	Strategic Planner For Employee Health	King County
9. Julie Sylvester	Vice President of Quality and Safety Initiatives	Qualis Health
10. Jay Tihinen	Assistant Vice President, Benefits	Costco

ADDICTION AND DEPENDENCE TREATMENT

Member	Title	Organization
1. Charissa Fotinos, MD, MSc	Deputy Chief Medical Officer	Health Care Authority
2. Tom Fritz (Chair)	Chief Executive Officer	Inland Northwest Health Services
3. Linda Grant	Chief Executive Officer	Evergreen Manor
4. Tim Holmes	Vice President of Outreach Services and Behavioral Health Administration	MultiCare Health System
5. Ray Hsiao, MD	Co-Director, Adolescent Substance Abuse Program	Seattle Children's Hospital
6. Scott Munson	Executive Director	Sundown M Ranch
7. Rick Ries, MD	Associate Director	Addiction Psychiatry Residency Program, University of Washington
8. Terry Rogers, MD	Chief Executive Officer	Foundation for Health Care Quality
9. Ken Stark	Director	Snohomish County Human Services Department
10. Jim Walsh, MD	Physician	Swedish Medical Center

ALZHEIMER'S DISEASE AND OTHER DEMENTIAS

Name	Title	Organization
1. Kimiko Domoto-Reilly, MD	Alzheimer's Research Center	University of Washington Medicine
2. Richard Furlong, MD	Primary Care	Virginia Mason Medical Center
3. Barak Gaster, MD	Professor of Medicine	University of Washington Medicine
4. Kelly Green, LICSW	Social Worker	Evergreen Health
5. Debbie Hunter	Family Caregiver	
6. Nancy Isenberg, MD, MPH, FAAN	Neurologist, Clinical Associate Professor of Neurology, Center for Healthy Aging & Memory	Virginia Mason Medical Center
7. Arlene Johnson	Family Caregiver	
8. Kerry Jurges, MD	Primary Care	Confluence Health
9. Eric Larson, MD, MPH	Vice President for Research and Health Care Innovation	Kaiser Foundation Health Plan of Washington
10. Todd Larson	Family Caregiver	
11. Myriam Marquez	Patient Advocate	
12. Shirley Newell, MD	Chief Medical Officer	Aegis Living
13. Darrell Owens, DNP, ARNP	Clinic Chief, Director	University of Washington Outpatient Primary, Palliative and Supportive Care Program
14. Kristoffer Rhoads, PhD (Chair)	Primary Neuropsychologist, Memory and Brain Wellness Center	University of Washington Medicine
15. Tatiana Sadak, PhD, ARNP	Psychiatric Nurse Practitioner	University of Washington Medical Center

16. Bruce Smith, MD	Medical Director	Regence Blue Shield

BEHAVIORAL HEALTH INTEGRATION

Member	Title	Organization
1. Brad Berry	Executive Director	Consumer Voices Are Born
2. Regina Bonnevie, MD	Medical Director	Peninsula Community Health Services
3. Mary Hodge-Moen, MSW, LMHC, CDP, CCM	Sr. Manager, Clinical Review	Premera
4. Rose Ness, MA, LMHC, CDP	Behavioral Health Expert	Sound Integration for Behavioral Healthcare
5. Mary Kay O'Neill MD, MBA	Partner	Mercer
6. Joe Roszak	CEO	Kitsap Mental Health Services
7. Anna Ratzliff, MD, PhD/ Anne Shields, MHA, RN	Director of the UW Integrated Care Training Program, Associate Director for Education/Associate Director	AIMS Center, University of Washington
8. Brian Sandoval, PsyD	Behavioral Health Manager, Oregon and Washington Services	Yakima Valley Farmworkers Clinics
9. Lani Spencer, RN, MHA	Vice President	Health Care Management Services, Amerigroup – Washington
10. Emily Transue, MD, MHA	Senior Medical Director	Coordinated Care

BREE IMPLEMENTATION TEAM

Member	Title	Organization
1. Neil Chasan	Physical Therapist	Sports Reaction Center
2. Susie Dade, MS	Deputy Director	Washington Health Alliance
3. Cezanne Garcia	Program Manager, Community and School-Based Partnerships	Public Health Seattle – King County
4. Ellen Kauffman, MD	OB-COAP Medical Director	Foundation for Health Care Quality
5. Dan Lessler, MD (Chair)	Medical Director	Health Care Authority
6. Alice Lind, RN	Manager, Grants and Program Development	Health Care Authority
7. Jason McGill, JD	Health Policy Advisor	Governor's Office
8. Larry McNutt	Sr. Vice President	Northwest Administrators, Inc.
9. Mary Kay O'Neill, MD, MBA	Chief Medical Director	Coordinated Care
10. Steven Overman, MD	Director	Seattle Arthritis Clinic
11. Terry Rogers, MD	Chief Executive Officer	Foundation for Health Care Quality
12. Claudia Sanders	Senior Vice President, Policy Development	Washington State Hospital Association
13. Kerry Schaefer, MS	Strategic Planner for Employee Health	King County
14. Jeff Thompson, MD	Senior Health Care Consultant	Mercer
15. Shawn West, MD	Family Physician	

Member	Title	Organization
16. Karen Wren	Benefits Manager	Point B

COLLABORATIVE CARE FOR CHRONIC PAIN		
Member	**Title**	**Organization**
1. LuAnn Chen, MD, MHA, FAAFP	Medical Director	Community Health Plan of Washington
2. Lynn DeBar, PhD, MPH	Senior Investigator	Kaiser Permanente Washington Health Research Institute
3. Stuart Freed, MD	Chief Medical Officer	Confluence Health
4. Andrew Friedman, MD	Physiatrist	Virginia Mason Medical Center
5. Leah Hole-Marshall, JD (chair)	Counsel and Chief Strategist	Washington Health Benefit Exchange
6. Mary Kay O'Neill, MD, MBA	Partner	Mercer
7. Jim Rivard, PT, DPT, MOMT, OCS, FAAOMPT	President	MTI Physical Therapy
8. Kari A. Stephens, PhD	Assistant Professor – Psychiatry & Behavioral Sciences	University of Washington Medicine
9. Mark Sullivan, MD, PhD	Professor, psychiatry; Adjunct professor, anesthesiology and pain medicine	University of Washington Medicine
10. Emily Transue, MD, MHA	Associate Medical Director	Washington State Health Care Authority

COLORECTAL CANCER SCREENING

Member	Title	Organization
1. Patricia Auerbach, MD, MBA, FACP	Chief Medical Officer, Washington, Oregon, and Idaho, Employer & Individual, Medicare & Retirement	UnitedHealthcare
2. Elizabeth Broussard, MD	Gastroenterology	Pacific Medical Centers First Hill
3. Jason Dominitz, MD, MHS	National Director of Gastroenterology	VA Puget Sound
4. Casey Eastman, MPH	Content Lead, Breast, Cervical, Colon Health Program	Washington State Department of Health
5. Bev Green, MD, MPH	Senior Investigator, Family Physician	Kaiser Permanente Washington
6. Tracey Hugel, MSN, RN	Senior Clinical Program Consultant	Regence
7. John Inadomi, MD	Gastroenterology	University of Washington Medicine
8. Rachel Issaka, MD, MAS	Assistant Member, Gastroenterology and Hepatology Clinical Research Division	Fred Hutch
9. Hagen Kennecke, MD	Medical Oncology	Virginia Mason
10. Rick Ludwig, MD (Chair)	Chief Executive Officer	Pacific Medical Centers
11. Val Simianu, MD, MPH	Colon and rectal Surgeon	Virginia Mason
12. Julie Stofel	Patient and Family Advocate	
13. Tammy Wild, MPH, RDN, LD, NSCA-CPT	State Health Systems Manager	American Cancer Society

END-OF-LIFE CARE

Member	Title	Organization
1. Anna Ahrens	Director of Patient and Family Support Services	MultiCare Health System
2. J. Randall Curtis, MD, MPH	Professor of Medicine, Director	University of Washington Palliative Care Center of Excellence
3. Trudy James	Chaplain	Heartwork
4. Bree Johnston, MD	Medical Director, Palliative Care	PeaceHealth
5. Abbi Kaplan	Principal	Abbi Kaplan Company
6. Timothy Melhorn, MD	Internist	Yakima Valley Memorial Hospital (YVMH) and the Memorial Foundation
7. Joanne Roberts, MD	Chief Medical Officer, NMR Administration	Providence Everett Regional Medical Center
8. John Robinson, MD (Chair)	Chief Medical Officer	First Choice Health
9. Bruce Smith, MD (Vice-Chair)	Associate Medical Director, Strategy Deployment	Group Health Physicians
10. Richard Stuart, DSW	Clinical Professor Emeritus, Psychiatry	University of Washington

HOSPITAL READMISSIONS

Member	Title	Organization
1. Sharon Eloranta, MD	Medical Director, Quality and Safety Initiatives	Qualis Health
2. Stuart Freed, MD	Medical Director	Wenatchee Valley Medical Center
3. Rick Goss, MD, MPH (Chair)	Medical Director	Harborview Medical Center – University of Washington
4. Leah Hole-Marshall, JD	Medical Administrator	Washington State Department of Labor and Industries
5. Dan Lessler, MD, MHA	Medical Director	Health Care Authority
6. Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
7. Amber Theel, RN, MBA	Director, Patient Safety Practices	Washington State Hospital Association

HYSTERECTOMY

Member	Title	Organization
1. Pat Kulpa, MD, MBA	Medical Director	Regence BlueShield
2. Sharon Kwan, MD, MS	Interventional Radiologist	University of Washington Medical Center
3. John Lenihan, MD	Medical Director of Robotics and Minimally Invasive Surgery	MultiCare Health System
4. Jennie Mao, MD	Clinical Assistant Professor, Department of Obstetrics and Gynecology	University of Washington Medical Center
5. Sarah Prager, MD	Chair	Washington State Section of ACOG
6. Kevin Pieper, MD	Chief, Women's and Children's	Providence Regional Medical Center Everett
7. Kristin Riley, MD, FACOG	Assistant Professor, Department of Obstetrics and Gynecology	University of Washington Medical Center
8. Jeanne Rupert, DO, PhD (Chair)		
9. Anita Showalter, DO, FACOOG	Associate Professor and Chair, Women's Health	Pacific Northwest University of Health Sciences
10. Susan Warwick, MD	Obstetrics and Gynecology	Kaiser Permanente

LGBTQ HEALTH CARE		
Member	**Title**	**Organization**
1. Olivia Arakawa, MSN, CNM, ARNP, RN	Parent Advocate	
2. Scott Bertani	Director of Policy	Lifelong AIDS Alliance
3. Kathy Brown, MD	Provider	Kaiser Permanente
4. LuAnn Chen, MD, MHA, FAAFP	Medical Director	Community Health Plan of Washington
5. Michael Garrett, MS, CCM, CVE, NCP	Principal	Mercer
6. Chris Gaynor, MD, MA, FAAFP	Family Practice Clinician	Capitol Hill Medical
7. Matt Golden, MD	Professor, Director, PHSKC STD Control Program	University of Washington
8. Kevin Hatfield, MD	Family Practice Clinician	The Polyclinic
9. Corinne Heinen, MD	Physician Lead, UW Transgender Clinical Pathway	Department of Internal Medicine, Allergy & Infectious Disease, University of Washington
10. Tamara Jones, MPH	End AIDS Washington Policy and Systems Coordinator	Department of Health
11. Dan Lessler, MD, MHA (Chair)	Chief Medical Officer	Washington State Health Care Authority

LOW BACK PAIN

Member	Title	Organization
1. Dan Brzusek, DO	Physiatrist	Northwest Rehab Association
2. Neil Chasan	Physical Therapist	Sport Reaction Center
3. Andrew Friedman, MD	Physiatrist	Virginia Mason
4. Leah Hole-Curry, JD	Medical Administrator	Washington State Department of Labor and Industries
5. Heather Kroll, MD	Rehab Physician	Rehab Institute of Washington
6. Chong Lee, MD	Spine Surgeon	Group Health Cooperative
7. Mary Kay O'Neill, MD, MBA (Chair)	Executive Medical Director	Regence Blue Shield
8. John Robinson, MD, SM	Chief Medical Officer	First Choice Health
9. Michael Von Korff, ScD	Psychologist & Researcher	Group Health Research Institute
10. Kelly Weaver, MD	Physiatrist	The Everett Clinic

MATERNITY BUNDLED PAYMENT

Member	Title	Organization
1. David Buchholz, MD	Medical Director, Collaborative Health Care Solutions	Premera
2. Andrew Castrodale, MD	Family Physician	Coulee Medical Center
3. Francie Chalmers, MD	Pediatrician, Member	Washington Chapter of the American Academy of Pediatrics
4. Angela Chien, MD	Obstetrics and Gynecology	EvergreenHealth
5. Neva Gerke, LM	President	Midwives Association of Washington
6. Molly Firth, MPH	Patient Advocate	
7. Lisa Humes-Schulz, MPA/ Lisa Pepperdine, MD	Director of Strategic Initiatives/ Director of Clinical Services	Planned Parenthood of the Great Northwest and Hawaiian Islands
8. Rita Hsu, MD, FACOG	Obstetrics and Gynecology	Confluence Health
9. Carl Olden, MD (Chair)	Family Physician	Pacific Crest Family Medicine
10. Dale Reisner, MD	Obstetrics and Gynecology	Swedish Medical Center
11. Janine Reisinger, MPH	Director, Maternal-Infant Health Initiatives	Washington State Hospital Association
12. Mark Schemmel, MD	Obstetrics and Gynecology	Spokane Obstetrics and Gynecology, Providence Health and Services
13. Vivienne Souter, MD	Research Director	Obstetrics Clinical Outcomes Assessment Program
14. Judy Zerzan, MD	Chief Medical Officer	Washington State Health Care Authority

OBSTETRIC (MATERNITY) CARE

Member	Title	Organization
1. Theresa Helle	Manager, Health Care Quality & Efficiency Initiatives	The Boeing Company
2. Ellen Kauffman, MD	OB-COAP Medical Director	Foundation for Health Care Quality
3. Robert Mecklenburg, MD	Medical Director, Center for Health Care Solutions	Virginia Mason Medical Center
4. Carl Olden, MD (Chair)	Family Physician	Pacific Crest Family Medicine, Yakima
5. Mary Kay O'Neill, MD, MBA	Executive Medical Director	Regence Blue Shield
6. Dale Reisner, MD	Obstetrician/Gynecologist	Swedish Hospital Perinatologist
7. Terry Rogers, MD	Chief Executive Officer	Foundation for Health Care Quality
8. Roger Rowles, MD	Obstetrician/Gynecologist	Yakima Memorial OB-GYN

ONCOLOGY CARE

Member	Title	Organization
1. Jennie Crews, MD	Medical Director	PeaceHealth St. Joseph Cancer Center
2. Bruce Cutter, MD	Oncologist	Medical Oncology Associates
3. Patricia Dawson, MD, PhD	Director	Swedish Cancer Institute Breast Program and True Family Women's Cancer Center
4. Keith Eaton, MD, PhD	Medical Director, Quality, Safety and Value	Seattle Cancer Care Alliance
5. Janet Freeman-Daily	Patient Advocate	
6. Christopher Kodama, MD, MBA (Chair)	President, MultiCare Connected Care	MultiCare Health System
7. Gary Lyman, MD, MPH	Co-Director	Hutchinson Institute for Cancer Outcomes Research
8. Rick McGee, MD	Oncologist	Washington State Medical Oncology Society
9. John Rieke, MD,FACR	Medical Director	MultiCare Regional Cancer Center
10. Hugh Straley, MD	Chair and Oncologist	Bree Collaborative
11. Richard Whitten, MD	Medical Director	Noridian

ONCOLOGY CARE (2020)

Member	Title	Organization
1. Sibel Blau, MD	Oncologist	Northwest Medical Specialties
2. Andra Davis, PhD, MN, BSN	Assistant Professor, Vancouver	Washington State University
3. Gurpreet Dhillon, MBA	Director, Hospice, Palliative Care and PeaceHealth St. Joseph Cancer Center Service Lines	PeaceHealth
4. Stefanie Hafermann, DNP, BSN, RN, PHN	Director of Program Development	Regence
5. Blair Irwin, MD, MBA	Oncologist	Multicare Regional Cancer Center
6. Barb Jensen, RN, BSN, MBA	Director of Oncology and Palliative Care	Skagit Regional Health
7. Sasha Joseph, MD	Medical Director of Medical Oncology	Multicare
8. Laura Panattoni, PhD	Staff Scientist	Hutchinson Institute for Cancer Outcomes Research
9. Camille Puronen, MD	Oncologist	Kaiser Permanente Washington
10. Hugh Straley, MD (Chair)	Chair	Bree Collaborative
11. Nancy Thompson, RN, MS, AOCNS	Director, Quality & Clinical Practice	Swedish Cancer Institute

OPIOIDS: LONG TERM OPIOID USE

Member	Title	Organization
1. Rose Bigham and Cyndi Hoenhous (Co-Chairs)	Patient Advocates	Washington Patients in Intractable Pain
2. Pamela Stitzlein Davies, MS, ARNP, FAANP	Nurse Practitioner	Departments of Neurology & Nursing, University of Washington
3. Jason Fodeman, MD	Associate Medical Director	Washington State Department of Labor and Industries
4. Charissa Fotinos, MD (Co-Chair)	Deputy Medical Officer	Washington State Health Care Authority
5. Gary Franklin, MD, MPH (Chair)	Medical Director	Department of Labor and Industries
6. Andrew Friedman, MD	Physical Medicine and Rehabilitation	Virginia Mason Medical Center
7. Kelly Golob, DC	Chiropractor	Tumwater Chiropractic Center
8. Dan Kent, MD	Chief Medical Officer	UnitedHealthcare
9. Kathy Lofy, MD	Chief Science Officer	Department of Health
10. Jaymie Mai, PharmD	Pharmacy Manager	Department of Labor and Industries
11. Andrew Saxon, MD (Co-Chair)	Director, Center of Excellence in Substance Abuse Treatment and Education (CESATE)	VA Puget Sound Health Care System
12. Mark Stephens	President	Change Management Consulting
13. Mark Sullivan, MD, PhD	Psychiatrist	University of Washington

Member	Title	Organization
14. David Tauben, MD	Chief of Pain Medicine	University of Washington Medical Center
15. Gregory Terman, MD, PhD	Professor	Department of Anesthesiology and Pain Medicine and the Graduate Program in Neurobiology and Behavior, University of Washington
16. John Vassall, MD, FACP	Physician Executive for Quality and Safety	Comagine Health

OPIOID PRESCRIBING GUIDELINE IMPLEMENTATION

Member	Title	Organization
1. Chris Baumgartner	Director Prescription Monitoring Program	Department of Health
2. David Buchholz, MD	Medical Director of Provider Engagement	Premera
3. Tanya Dansky, MD	Chief Medical Officer	Amerigroup
4. Gary Franklin, MD, MPH (Chair)	Medical Director	Department of Labor and Industries
5. Charissa Fotinos, MD, MSc	Deputy Chief Medical Officer	Health Care Authority
6. Frances Gough, MD	Chief Medical Officer	Molina Healthcare
7. Kathy Lofy, MD	Chief Science Officer	Department of Health
8. Jaymie Mai, PharmD	Pharmacy Manager	Department of Labor and Industries

Member	Title	Organization
9. Mark Murphy, MD	Addiction Medicine	MultiCare Health System
10. Shirley Reitz, PharmD	Clinical Pharmacist Client Manager	OmedaRx, Cambia
11. Gregory Rudolph, MD	Addiction Medicine	Swedish Pain Services
12. Michael Schiesser, MD	Addiction Medicine	EvergreenHealth Medical Center
13. Danny Stene, MD	Medical Director	First Choice Health
14. Mark Stephens	President	Change Management Consulting
15. Hugh Straley, MD	Chair	Bree Collaborative
16. David Tauben, MD	Chief of Pain Medicine	University of Washington (UW) Medical Center
17. Gregory Terman MD, PhD	Professor	Dept. of Anesthesiology and Pain Medicine; Graduate Program, Neurobiology and Behavior, UW
18. Emily Transue, MD	Chief Medical Director	Coordinated Care
19. Michael Von Korff, ScD	Senior Investigator	Group Health Research Institute
20. Melet Whinston, MD	Medical Director	United Health Care

OPIOID USE DISORDER TREATMENT

Member	Title	Organization
1. Jane Ballantyne, MD, FRCA	Professor, Department of Anesthesiology and Pain Medicine	University of Washington School of Medicine
2. Caleb Banta-Green, PhD, MPH, MSW	Senior Scientist	Alcohol and Drug Abuse Institute, University of Washington
3. David Beck, MD	Immediate Past President	Washington Society of Addiction Medicine
4. Ryan Caldeiro, MD	Chief Chemical Dependency Services and Consultative Psychiatry	Kaiser Permanente
5. Mary Catlin, BSN, MPH	Institutional Nurse Consultant	Department of Health
6. Charissa Fotinos, MD, MSc (Co-Chair)	Deputy Medical Officer	Health Care Authority
7. Nancy Lawton, MN, ARNP, FNP	President	ARNPs United of Washington State
8. Darin Neven, MD, MS	President and Founder	Consistent Care
9. Richard Ries, MD	Director, Addiction Psychiatry Residency Program	University of Washington
10. John Robinson, MD, SM	Chief Medical Officer	First Choice Health
11. John Roll, PhD	Professor & Vice Dean for Research, Elson S. Floyd College of Medicine	Washington State University
12. Terry Rogers, MD	Medical Director	Lakeside Milam Recovery
13. Vania Rudolf, MD, MPH	Addiction Recovery Services	Swedish Medical Center

Member	Title	Organization
14. Andrew Saxon, MD (Co-Chair)	Director, Center of Excellence in Substance Abuse Treatment and Education (CESATE)	VA Puget Sound Health Care System
15. Mark Stephens	President	Change Management Consulting
16. Milena Stott, LICSW, CDP	Chief Of Inpatient Services	Valley Cities Counseling

PALLIATIVE CARE

Member	Title	Organization
1. John Robinson, MD, SM (Chair)	Chief Medical Officer	First Choice Health
2. Lydia Bartholomew, MD	Senior Medical Director, Pacific Northwest	Aetna
3. George Birchfield, MD	Inpatient Hospice	EvergreenHealth
4. Raleigh Bowden, MD	Director	Okanogan Palliative Care Team
5. Mary Catlin, MPH	Senior Director	Honoring Choices, Washington State Hospital Association
6. Randy Curtis, MD, MPH	Director, Cambia Palliative Care Center of Excellence	University of Washington Medicine
7. Leslie Emerick	Director of Public Policy	Washington State Hospice and Palliative Care Organization
8. Ross M Hays, MD	Director, Palliative Care Program	Seattle Children's
9. Greg Malone, MA, Mdiv, BCC	Mgr Palliative Care Services, & Spiritual Care Provider	Swedish Medical Center
10. Kerry Schaefer, MS	Strategic Planner for Employee Health	King County

Member	Title	Organization
11. Bruce Smith, MD	Medical Director of Providence Hospice of Seattle	Providence Health and Services
12. Richard Stuart, DSW	Psychologist	Swedish Medical Center – Edmonds Campus
13. Stephen Thielke, MD	Geriatric Psychiatry	University of Washington
14. Cynthia Tomik, LICSW	Manager, Palliative Care	EvergreenHealth
15. Gregg Vandekieft, MD, MA	Medical Director for Palliative Care	Providence St. Peter Hospital
16. Hope Wechkin, MD	Medical Director, Hospice and Palliative Care	EvergreenHealth

PROSTATE CANCER SCREENING

Member	Title	Organization
1. John Gore, MD, MS	Urologist, clinician, surgeon, researcher	University of Washington Medicine
2. Matt Handley, MD	Medical Director, Quality	Group Health Cooperative
3. Leah Hole-Marshall, JD	Medical Administrator	Department of Labor & Industries
4. Steve Lovell	Retired	Patient and Family Advisory Council
5. Wm. Richard Ludwig, MD (Chair)	Chief Medical Officer	Providence Accountable Care Organization
6. Bruce Montgomery, MD	Clinical Director of Genitourinary Medical Oncology	Seattle Cancer Care Alliance
7. Eric Wall, MD, MPH	Market Medical Director	UnitedHealthcare

8.	Shawn West, MD	Family Physician	Edmonds Family Medicine
9.	Jonathan Wright, MD, MS, FACS	Assistant professor of urology/affiliate researcher	University of Washington/Fred Hutchinson Cancer Research Center

PEDIATRIC PSYCHOTROPIC USE

Member	Title	Organization
1. Shelley Dooley	Parent Advocate	
2. Nalini Gupta, MD	Pediatrician	Developmental and Behavioral Pediatrics, Providence Health and Services
3. Robert Hilt, MD	Director, Community Leadership; Director of Partnership Access Line	Seattle Children's
4. Paula Lozano, MD, MPH (Chair)	Medical Director, Research and Translation	Group Health Cooperative
5. Liz Pechous, PhD	Clinical Director	ICARD, PLLC
6. Robert Penfold, PhD	Co-investigator, Mental Health Research Network	Group Health Research Institute
7. James Polo, MD, MBA	Chief Medical Officer	Western State Hospital
8. David Testerman, PharmD	Pharmacy Director	Amerigroup
9. Mark Stein, PhD, ABPP	Director of ADHD and Related Disorders	Seattle Children's
10. Donna Sullivan, PharmD, MS	Chief Pharmacy Officer	Washington Health Care Authority

PRIMARY CARE

Member		Title	Organization
1.	Patricia Auerbach, MD, MBA	Senior Medical Director	UnitedHealthcare
2.	Cynthia Burdick, MD	Medical Director, Medicare and Medicaid	Kaiser Permanente Washington
3.	Tony Butruille, MD	Chair, Primary Care Investment Task Force	Washington Academy of Family Physicians
4.	Susie Dade, MS	Deputy Director	Washington Health Alliance
5.	Jason Fodeman, MD	Associate Medical Director	Washington State Department of Labor and Industries
6.	Bianca Frogner, PhD	Associate Professor, Family Medicine; Director of Center for Health Workforce Studies	University of Washington School of Medicine
7.	Ingrid Gerbino, MD, FACP	Chief, Department of Primary Care	Virginia Mason
8.	Karen Johnson, PhD, MHSA (replacing Susie Dade)	Director of Performance Improvement and Innovation	Washington Health Alliance
9.	Louise Kaplan, PhD, ARNP, FNP-BC, FAANP, FAAN	Associate Professor, Associate Academic Director	Washington State University Vancouver College of Nursing
10.	Catherine Mazzawy	Senior Director, Safety and Quality	Washington State Hospital Association
11.	Carl Olden, MD	Family Physician	Virginia Mason Memorial
12.	Mary Kay O'Neill, MS, MBA	Partner	Mercer
13.	Ashok Reddy, MD, MS	Assistant Professor, Medicine	University of Washington School of Medicine, Veterans Administration
14.	Keri Waterland, PhD, MAOB	Division Director, Division of Behavioral Health and Recovery	Health Care Authority

Member		Title	Organization
15.	Laura Kate Zaichkin, MPH	Director, Health Plan Performance and Strategy	SEIU 775 Benefits Group
16.	Judy Zerzan, MD, MPH (Chair)	Chief Medical Officer	Washington State Health Care Authority

REPRODUCTIVE AND SEXUAL HEALTH

Member		Title	Organization
1.	Trish Anderson, MBA	Senior Director, Safety and Quality	Washington State Hospital Association
2.	Janet Cady, ARNP	Medical Director, School Based Program	Neighborcare
3.	Angela Chien, MD	Obstetrics and Gynecology	EvergreenHealth
4.	Paul Dillon/Lili Navarrete	Latinx Outreach & Organizing Program	Planned Parenthood of Greater Washington and North Idaho
5.	Colin D. Fields, MD	Chief, Gender Health Program	Kaiser Permanente Washington
6.	Charissa Fotinos, MD (Chair)	Deputy Chief Medical Officer	Washington State Health Care Authority
7.	Leo Gaeta	Vice President of Programs	The Columbia Basin Health Association
8.	Cynthia Harris, PhD	Family Planning Program Manager	Department of Health
9.	Leigh Hofheimer	Program Coordinator	Washington State Coalition Against Domestic Violence
10.	Rita Hsu, MD, FACOG	Obstetrics and Gynecology	Confluence Health
11.	Heather Maisen, MPH, MSW	Family Planning Program Manager	Public Health – Seattle & King County
12.	Adrianne Moore	Deputy Director of Quality Improvement	Upstream
13.	Ivanova Smith	Patient Advocate	UW LEND Faculty
14.	Mandy Weeks-Green	Senior Health Policy Analyst	Officer of the Insurance Commissioner

Member		Title	Organization
15.	Catherine West, JD	Staff Attorney	Legal Voice (formerly Northwest Women's Law Center)
16.	Giselle Zapata-García	Co-Director	Latinos Promoting Good Health (also Latinx Health Board, Executive Committee Co-Chair)

RISK OF VIOLENCE TO OTHERS

Member	Title	Organization
1. G. Andrew Benjamin, JD, PhD, ABPP	Clinical Psychologist, Affiliate Professor of Law	University of Washington
2. Kate Comtois, PhD, MPH	Professor	Department of Psychiatry and Behavioral Sciences Harborview Medical Center
3. Jaclyn Greenberg, JD, LLM	Policy Director, Legal Affairs	Washington State Hospital Association
4. Laura Groshong, LICSW	Private Practitioner	Washington State Society for Clinical Social Work
5. Ian Harrel, MSW	Chief Operating Officer	Behavioral Health Resources
6. Marianne Marlow, MA, LMHC	Member	Washington Mental Health Counseling Association
7. Neetha Mony	State Suicide Prevention Plan Program Manager, Injury & Violence Prevention, Prevention and Community Health	Washington State Department of Health
8. Kim Moore, MD (Chair)	Associate Chief Medical Director	CHI Franciscan
9. Kelli Nomura, MBA	Behavioral Health Administrator	King County
10. Mary Ellen O'Keefe, ARNP, MN, MBA	Clinical Nurse Specialist – Adult Psychiatric/Mental Health Nursing; President Elect	Association of Advanced Psychiatric Nurse Practitioners
11. Jennifer Piel, MD, JD	Psychiatrist	Department of Psychiatry, University of Washington
12. Jeffrey Sung, MD	Member	Washington State Psychiatric Association
13. Samantha Slaughter, PsyD	Member	WA State Psychological Association

Member	Title	Organization
14. Adrian Tillery		Harborview Mental Health and Addiction Services
15. Amanda Ibaraki Stine, LMFT	Member	Washington Association for Marriage and Family Therapists

SHARED DECISION MAKING

Member	Title	Organization
1. David Buchholz, MD	Medical Director	Premera
2. Sharon Gilmore, RN	Risk Consultant	Coverys
3. Leah Hole-Marshall, JD	General Counsel and Chief Strategist	Washington Health Benefit Exchange
4. Steve Jacobson MD, MHA, CPC	Associate Medical Director Care Coordination	The Everett Clinic, a DaVita Medical Group
5. Dan Kent, MD	Medical Director	United Health Care
6. Andrew Kartunen	Program Director, Growth & Strategy	Virginia Mason Medical System
7. Dan Lessler, MD, MHA	Physician Executive for Community Engagement and Leadership	Comagine Health
8. Jessica Martinson, MS	Director of Clinical Education and Professional Development	Washington State Medical Association
9. Karen Merrikin, JD	Consultant	Washington State Health Care Authority
10. Randy Moseley, MD	Medical Director of Quality	Confluence Health
11. Martine Pierre Louis, MPH	Director of Interpreter Services	Harborview
12. Karen Posner, PhD	Research Professor, Laura Cheney Professor in Anesthesia Patient Safety	Department of Anesthesiology and Pain Medicine, University of Washington
13. Angie Sparks, MD	Family Physician and Medical Director Clinical Knowledge Development	Kaiser Permanente
14. Anita Sulaiman	Patient Advisor and Consultant	IBEX

Member	Title	Organization
15. Emily Transue, MD, MHA (Chair)	Associate Medical Director	Washington State Health Care Authority

SUICIDE CARE

Member	Title	Organization
1. Kate Comtois, PhD, MSW	Psychologist	Harborview Medical Center
2. Karen Hye, PsyD	Clinical Psychologist	CHI Franciscan Health
3. Matthew Layton, MD, PhD, FACP, DFAPA	Clinical Professor, Department of Medical Education and Clinical Sciences	Elson S. Floyd College of Medicine, Washington State University
4. Neetha Mony, MSW	Statewide Suicide Prevention Plan Program Manager	Washington State Department of Health
5. Julie Rickard, PhD	Physician & Healthcare Consultant	Confluence Health
6. Julie Richards, MPH	Research Associate	Kaiser Permanente Washington Health Research Institute
7. Hugh Straley, MD (Chair)	Chair	Bree Collaborative
8. Jennifer Stuber, PhD	Associate Professor	University of Washington School of Social Work
9. Jeffrey Sung, MD	Member	Washington State Psychiatric Association

APPENDIX E: SUMMARY OF FIRST EIGHT YEARS

The Bree Collaborative workgroup members' engagement and dedication has yielded multiple high-quality and well-received sets of recommendations since its founding in 2011.

Recommendation topics to date include:

- Accountable Payment Models
  - Bariatric Surgery (2016)
  - Coronary Artery Bypass Graft Surgery (2015)
  - Lumbar Fusion (2014, re-reviewed 2018)
  - Total Knee and Total Hip Replacement Re-Review (2013, re-reviewed 2017)
- Addiction and Dependence Treatment (2014)
- Alzheimer's Disease and Other Dementias (2017)
- Cardiology (2013)
- Collaborative Care for Chronic Pain (2018)
- Behavioral Health Integration (2016)
- End-of-Life Care (2014)
- Hysterectomy (2017)
- Lesbian, Gay, Bisexual, Transgender, and Questioning or Queer Health Care (2018)
- Low Back Pain and Spine Surgery (2013)
- Maternity Bundled Payment Model (2019)
- Obstetric Care (2012)
- Oncology Care (2015)
- Opioid Prescribing
  - Dental Care (2017)
  - Metrics (2017)
  - Long-Term Opioid Therapy (2020)
  - Post-operative Care (2018)
- Opioid Use Disorder Treatment (2016)
- Palliative Care (2019)
- Pediatric Psychotropic Use (2016)
- Potentially Avoidable Hospital Readmissions (2014)
- Prostate Cancer Screening (2015)
- Risk of Violence to Others (2019)
- Shared Decision Making (2019)
- Suicide Care (2018)

ACCOUNTABLE PAYMENT MODELS: BARIATRIC SURGERY

Adopted November 2016 | Approved by HCA in February 2017

- **Read the Bariatric Surgical Bundled Payment Model here:** www.breecollaborative.org/wp-content/uploads/Bree-Bariatric-Bundle-Final-2016.pdf
- **Read the Bariatric Surgical Warranty here:** www.breecollaborative.org/wp-content/uploads/Bariatric-Warranty-Final-2016.pdf
- **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/Bariatric-Evidence-Table-Final-2016.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/apm/
  - Workgroup met from February to November 2016
- **Background**
  - The National Institutes of Health (NIH) defines obesity as a body mass index of equal to or greater than 30 kg/m^2.[1] According to this NIH definition, more than one third of adults in the United States are obese. Obesity is associated with increased likelihood of type 2 diabetes, high blood pressure, hyperlipidemia, cardiovascular disease, obstructive sleep apnea, osteoarthritis, and gastroesophageal reflux (heartburn). The national annual cost of obesity and its consequences approaches $150 billion.[2]
  - While there is no reliable long-term cure, even modest reductions in weight loss can convey benefit by controlling associated conditions such as diabetes, high blood pressure, and high cholesterol.
- **Our recommendations**
  - The workgroup used the three previous models for elective total knee and total hip replacement, elective lumbar fusion, and coronary artery bypass surgery as models. The Bariatric Surgical Bundle provides a voluntary, community-based, evidence-informed standard for production, purchasing, and payment of health care based on quality.
  - The four proposed cycles include:
    - Eligibility due to obesity despite non-surgical therapy
    - Fitness for surgery
    - Bariatric surgery
    - Post-operative care and return to function
- **Implementation and Outcomes**
  - The Washington Health Alliance found significant variation in the likelihood of receiving bariatric surgery in 2016 with women aged 20-44 being more likely to receive the surgery and women aged 45-64 in Seattle being less likely than those in other cities. Source: Washington Health Alliance. Different Regions Different Care. wahealthalliance.org/wp-content/uploads/2016-different-regions-different-care.pdf

[1] Jensen MD, Ryan DH, Apovian CM, Ard JD, Comuzzie AG, Donato KA, et al. 2013 AHA/ACC/TOS guideline for the management of overweight and obesity in adults: a report of the American College of Cardiology/American Heart Association Task Force on Practice Guidelines and The Obesity Society. *Circulation*. 2014;129(25 Suppl 2):S102-38.

[2] Finkelstein EA, Trogdon JG, Cohen JW, Dietz W. Annual Medical Spending Attributable To Obesity: Payer-And Service-Specific Estimates. *Health Aff (Millwood)*. 2009;28(5):w822-31.

ACCOUNTABLE PAYMENT MODELS: CORONARY ARTERY BYPASS GRAFT SURGERY

Adopted September 2015 | Approved by HCA in October 2015

- **Read the CABG Bundled Payment Model here:** www.breecollaborative.org/wp-content/uploads/CABG-Bundle-Final-15-09.pdf
- **Read the CABG Warranty here:** www.breecollaborative.org/wp-content/uploads/CABG-Warranty-Final-15-09.pdf
- **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/CABG-Evidence-Table-Final-15-09.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/apm/
    - Workgroup met from February to September 2015
- **Background**
    - Coronary artery disease occurs due to plaque build-up on arterial walls is the leading cause of death in the United States.[3] This is often treated with coronary artery bypass graft surgery (CABG). CABG surgery has high variation among providers and institutions in price, utilization, and complication rates.[4] Bundled payments offer a mechanism to improve and standardize this care and have been shown to reduce cost along with improving patient outcomes.[5]
- **Our recommendations**
    - The workgroup used the previous two models on elective total knee and total hip replacement and elective lumbar fusion as a model. The intent of the CABG surgical bundle is to provide a community-based, evidence-informed standard for the production, purchasing, and payment of health care based on quality. The workgroup proposed a four-stage model requiring:
        - Disability despite non-surgical therapy
        - Fitness for surgery
        - The CABG procedure
        - Post-operative care and return to function
- **Implementation and Outcomes**
    - The 2016 implementation survey found high rates of adoption of the recommendations among hospitals and low rates among health plans.
    - Infections from cardiac surgery occur in 0.31% of cases. Blood clots developed and no preventative treatment was provided in 3% of cases (4% nationally), and serious complications occurred in 1% of surgeries (1% nationally). Source: Washington State Hospital Association. WA Hospital Quality. www.wahospitalquality.org/

ACCOUNTABLE PAYMENT MODELS: LUMBAR FUSION

[3] Centers for Disease Control and Prevention. Prevalence of Coronary Heart Disease. www.cdc.gov/mmwr/preview/mmwrhtml/mm6040a1.htm. Published October 2011. Accessed May 14, 2015.

[4] Chan PS, Spertus JA, Tang F, Jones P, Ho PM, Bradley SM, Tsai TT, Bhatt DL, Peterson PN. Variations in coronary artery disease secondary prevention prescriptions among outpatient cardiology practices: insights from the NCDR (National Cardiovascular Data Registry). *J Am Coll Cardiol*. 2014;63(6):539-46.

[5] Delbanco S. The Payment Reform Landscape: Bundled Payment. *Health Affairs Blog*. 2014. http://healthaffairs.org/blog/2014/07/02/the-payment-reform-landscape-bundled-payment.

Re-Review Adopted January 2019 | Approved by HCA February 2019

Originally Adopted September 2014 | Approved by HCA October 2014

- **Read the bundle and warranty here:** www.breecollaborative.org/wp-content/uploads/Lumbar-Fusion-Bundle-and-Warranty-Final-2018.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/previous-topics/apm/
    - Workgroup met from January to December 2018.
- **Background**
    - There is broad agreement that lumbar fusion surgery is appropriate to mitigate the immediate threat of spinal instability from major trauma, tumor, infection, or congenital anomalies. Lumbar fusion also clearly conveys benefit for some patients with less pressing indications. However, when we reviewed this topic in 2014, we also found a disproportionate rise in lumbar fusion compared to other spine surgeries, high variation in quality and billed charges, and evidence that for many patients considered candidates for elective lumbar fusion, there was no clear benefit of surgery compared to non-surgical care.
    - The health care community in 2017 asked the Bree Collaborative to revise the lumbar fusion bundle. They asked for expanded inclusion criteria to increase clinical impact (e.g., moving from a limit of single-level fusion to allow for second surgeries, multi-level fusions, and complex fusions). They also sought greater flexibility in administering the bundle to improve access in rural areas.
- **Our recommendations:**
    - Changes included greater flexibility for provider or hospital selection of patient-reported outcomes, better definitions of conservative therapy, clinical updates based on newly available evidence, and changes to the clinical pathway to facilitate more efficient care. The 2018 bundle also includes revisions to the quality standards and a warranty but retain the structure of the four cycle model of:
        - Disability despite non-surgical therapy. Specification of the degree of functional impairment, imaging findings confirming lumbar instability that correlate with the symptoms and signs, at least three months of structured non-surgical therapy delivered by a collaborative team, shared decision making.
        - Fitness for surgery. Minimum standards to ensure safety and commitment to participate actively in return to function.
        - Spinal fusion procedure. General standards for the surgical team, elements of the surgical process, participation in registries.
        - Post-operative care and return to function
- **Implementation and Outcomes**
    - Since January 2019, Capital Medical Center and Virginia Mason Medical Center have served as centers of excellence for PEBB Program members enrolled in Uniform Medical Plan for lumbar fusion bundled payment aligned with the Bree Collaborative recommendations.

Adopted November 2017 | Approved by HCA December 2017

Originally Adopted July 2013 | Approved by HCA October 2013

- **Read the bundle and warranty here:** www.breecollaborative.org/wp-content/uploads/TKRTHR-Bundle-Warranty-Final-2017.pdf
- **Read the evidence table here:** www.breecollaborative.org/wp-content/uploads/20171031_VM-EvidenceTables_TKR-THR.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/apm/
    - Workgroup met from December 2016 to November 2017.
- **Background**
    - Published hospital readmission rates for total knee and total hip replacements October 2013 available here: www.breecollaborative.org/wp-content/uploads/bree_summary_CHARS_Analysis.pdf
    - The total knee and total hip replacement bundle and warranty were originally adopted in July 2013 and November 2013 and approved by the HCA Director in April 2014.
    - The topic was selected for re-review in July 2016 and the revised version was adopted in November 2017 and approved by the HCA Director in December 2017.
- **Our recommendations**
    - The workgroup's goal is to improve patient safety, performance for providers, and affordability for purchasers through a four-stage model requiring:
        - Documenting disability despite explicit non-surgical care
        - Meeting fitness requirements for patients prior to surgery
        - Adhering to standards for best-practice surgery
        - Implementing a structured plan to rapidly return patients to function
- **Implementation and Outcomes**
    - The 2016 implementation survey found high rates of adoption of the 2012 recommendations among hospitals and low rates among health plans.
    - Since January 2017, Virginia Mason Medical Center has served as a center of excellence for PEBB Program members enrolled in Uniform Medical Plan for total knee and hip replacement with a waived co-insurance and travel and lodging reimbursement.
    - Since January 2019, Premera Blue Cross has contracted with seven Providence St. Joseph Health facilities as centers of excellence for total joint replacement following the Bree Collaborative guidelines.
    - Among Medicare recipients, the rate of complications for hip and knee replacements is 2.4% in Washington, 2.5% nationally; readmissions are 3.8% in Washington, 4% nationally. Source: Washington State Hospital Association. WA Hospital Quality. www.wahospitalquality.org/

ADDICTION AND DEPENDENCE TREATMENT

Adopted January 2015 | Approved by HCA in February 2015

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/ADT-Final-Report.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/adt/
  - Workgroup met from April 2014 to January 2015.
- Alcohol and drug abuse disorders lead to many debilitating health, economic, interpersonal, and social consequences with potentially long-lasting effects if left untreated. In Washington State, alcohol use leads to 11.1% of deaths of working age adults, higher than the national average.[6] Medicaid clients with a substance use disorder had significantly higher physical health expenditures and hospital admissions.[7]
- **Our recommendations**
  - Recommendations focus on the integration of screening, brief intervention, and referral to treatment in primary, prenatal, and emergency room settings rather than specific treatment modalities or therapies through adoption of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model. SBIRT is an evidence-based paradigm seeking to encourage health care providers to systematically "identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs."[8] The strength of the SBIRT model is providing early motivational conversations with people prior to alcohol and other drug misuse overly impacting their lives.
  - **Focus areas**
    - Reduce stigma associated with alcohol and other drug screening, intervention, and treatment
    - Increase appropriate alcohol and other drug use screening in primary care and emergency room settings
    - Increase capacity to provide brief intervention and/or brief treatment for alcohol and other drug misuse
    - Decrease barriers for facilitating referrals to appropriate treatment facilities
    - Address the opioid use disorder epidemic
- **Implementation and Outcomes**
  - The 2016 implementation survey found the lowest overall rate of adoption.
  - The two HCA Accountable Care Programs regularly train on the SBIRT model and have integrated a screening tool for alcohol use into electronic medical records and workflow.
  - Statewide in 2019, follow-up within 30 days after emergency room visit for alcohol or other drug abuse or dependence is 18% for those receiving commercial care and 12%

[6] Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of Excessive Alcohol Consumption to Deaths and Years of Potential Life Lost in the United States. *Prev Chronic Dis.* 2014;11:130293.

[7] Clark RE, Samnaliev M, McGovern MP. Impact of substance disorders on medical expenditures for Medicaid beneficiaries with behavioral health disorders. *Psychiatr Serv*. 2009;60(1):35-42.

[8] Substance Abuse and Mental Health Services Administration. SBIRT: Screening, Brief Intervention, and Referral to Treatment. Department of Health and Human Services. www.integration.samhsa.gov/clinicalpractice/SBIRT. Updated September 2017. Accessed November 2014.

within 7 days. Medicaid: of adults identified with a substance use disorder, 35% received at least one substance use disorder service in the year. For children this rate is 34%. Source: Washington Health Alliance. Washington Community Checkup. www.wacommunitycheckup.org.

Adopted November 2017 | Approved by HCA December 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Alzheimers-Dementia-Recommendations-Final-2017.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/alzheimers/
    - Workgroup met from January to November 2017.
- **Background**
    - The decline in memory and other cognitive functions and corresponding loss of independence because of dementia is a growing concern in our aging population. Age is the biggest risk factor for dementia with prevalence rates of 13.9% in those 71 and older increasing to 37.4% for those 90 and older.[9] Washington State has the third highest rate of death from Alzheimer's disease of any state and Alzheimer's is the third highest age-adjusted cause of death within the state overall.[10] The number of people diagnosed with dementia is expected to increase 40% in the next 10 years and 181% over the next 30 years.[5] However, in many practices in Washington State, there are no guidelines to address quality of care for diagnosis or ongoing supportive care.[11]
- **Our recommendations**
    - The workgroup's goal is to align care delivery with the existing evidence-based standard of care for each stage of disease and across health care settings for patients and their families and caregivers and build off the previous work within Washington State, specifically the Washington State Plan to Address Alzheimer's Disease and Other Dementia.
    - The workgroup recommends early detection of mild cognitive impairment to better support patients and family members, but does not recommend population-level screening of older adults. The workgroup also recommends using a strengths-based approach that empowers both the patient and the caregiver.[12]
    - **Focus Areas**
        - Diagnosis
        - Ongoing care and support or management
        - Advance care planning and palliative care
        - Need for increased support and/or higher levels of care
        - Preparing for potential hospitalization
        - Screening for delirium risk
- **Implementation and Outcomes**

[9] Plassman BL, Langa KM, Fisher GG, Heeringa SG, Weir DR, Ofstedal MB, et al. Prevalence of dementia in the United States: the aging, demographics, and memory study. *Neuroepidemiology*. 2007;29(1-2):125-32.

[10] Alzheimer's Association. Alzheimer's Statistics Washington. www.alz.org/media/Documents/washington-alzheimers-facts-figures-2018.pdf. Published March 3, 2017. Accessed July 2017.

[11] Washington State Department of Social and Health Services. Washington State Plan to Address Alzheimer's Disease and Other Dementias. www.dshs.wa.gov/sites/default/files/SESA/legislative/documents/2016%20WA%20Alzheimer%27s%20State%20Plan%20-%20Full%20Report%20Final.pdf. Published January 2016. Accessed February 1, 2017.

[12] Crum AJ, Leibowitz KA, Verghese A. Making mindset matter. *BMJ*. 2017;356:j674.

- The 2019 budget included funding for two areas related to the recommendations:
  - A dementia ECHO project to spread access to experts in dementia care to primary care sites in Washington State.
  - For part time staff within Aging and Long Term Support Administration, Developmental Disabilities Administration, Department of Health and HCA to improve communication and collaboration among these agencies and integrate dementia into strategic plans and efforts.

Adopted January 2013 | Approved by HCA January 2014

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/bree_bc_cardiology_final.pdf
- **Learn more about the process:** www.breecollaborative.org/topic-areas/cardiology/
- **Four-step process**
    - **Step 1:** Appropriate use insufficient information report with 2012 data by hospital posted on the COAP members-only section of the Clinical Outcomes Assessment Program (COAP) website. (*Completed August 2012)*
    - **Step 2**: COAP provides feedback and tools to hospitals to reduce insufficient information in data. (*Completed August to December 2012)*
    - **Step 3**: Updated Appropriate Use Insufficient Information report based on 4th Quarter 2012 data only, by hospital, given to Collaborative and hospitals to review. Hospitals had the option not to be identified. (*Completed May 2013)*
    - **Step 4**: After hospitals employed methods for improvement, an updated report based on 4th Quarter 2012 data only was posted on the public section of the COAP website. The Bree Collaborative also asked the Washington Health Alliance to post COAP data on its Community Checkup website, which compares data on health care services around the state. Hospitals had the option to not be identified. (*Completed June 2013)*

- **Implementation and Outcomes**
    - The 2016 implementation survey found hospitals reporting full adoption (3 out of a possible 3).
    - COAP uses data specifications and definitions from the American College of Cardiology's National Cardiovascular Data Repository (NCDR) in tracking processes and outcomes for patients receiving percutaneous cardiac intervention (PCI). NCDR released a new PCI registry version Q2 2018 with significant changes to the data metrics. The Appropriate Use Criteria (AUC) metrics were the only metrics not released and are still in development by NCDR. Currently, COAP has Appropriate Use data through Q1 2018 only. The most recent rolling four quarters of data available (Q2 2017-Q1 2018) showed that of the 3,443 Non Acute PCIs performed in Washington State, 23.8% could not be classified due to insufficient testing and/or documentation (from 36.4% in 2012). Of those 2,623 cases that were classified, 60.6% were Appropriate (from 41.1% in 2012), 26.8% were May Be Appropriate (from 38.1% in 2012), and 12.5% were Rarely Appropriate (from 20.2% in 2012). COAP will provide the remainder of 2018 AUC data once the new metrics have been released by NCDR and specifications have been built into the data system.

COLLABORATIVE CARE FOR CHRONIC PAIN

Adopted January 2019 | Approved by HCA in December 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Recommendations-Chronic-Pain-Final-2018.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/previous-topics/chronic-pain/
    - Workgroup met from January to November 2018.
- **Background**
    - About 11 percent of Americans experience chronic pain, defined as pain lasting three months or longer. Some surveys have estimated chronic pain to impact closer to 30 percent of our population.[13,14] Treating chronic pain is widely variable, with high financial and human cost. Research shows that moving to a collaborative or team-based approach to managing complex pain, based on models of care designed to manage chronic illness and depression, results in improved patient outcomes.[15,16] Additionally, researchers recommend multidisciplinary care (or using more than one approach) due to the complexity of pain.[17] However, most approaches to pain management, including chronic opioid therapy, involved siloed health care providers. There is also a lack of consensus around which elements of a systems-based model are critical and which resources are necessary to support the model.
- **Our recommendations**
    - This workgroup developed recommendations for collaborative care specific to chronic pain with life activity impacts. The recommendations are built on supporting patient self-management in the context of a biopsychosocial model and acknowledge the high number of people with unmet need due to gaps in or lack of comprehensive care.
    - Collaborative care uses primary care as the medical home for acute and chronic pain treatment and management through a systems-based approach with goals of improved function, increased quality of life, and greater patient autonomy rather than a primary focus on pain relief.
    - Focus areas include:
        - Patient identification and population management
        - A care team
        - A care management function
        - Basing treatments in evidence-informed care
        - Patient-centered supported self-management

[13] National Center for Complementary and Integrative Health. Pain in the U.S., August, 2015. https://nccih.nih.gov/news/press/08112015. Published August 2015. Accessed July 2018.

[14] Johannes CB, Le TK, Zhou X, Johnston JA, Dworkin RH. The prevalence of chronic pain in United States adults: results of an Internet-based survey. *J Pain*. 2010;11(11):1230-9.

[15] Katon WJ, Lin EH, Von Korff M, Ciechanowski P, Ludman EJ, Young B, Peterson D, Rutter CM, McGregor M, McCulloch D. Collaborative care for patients with depression and chronic illnesses. *N Engl J Med*. 2010;363:2611-20.

[16] Bodenheimer T, Wagner EH, Grumbach K. Improving primary care for patients with chronic illness: the chronic care model, Part 2. *JAMA*. 2002;288:1909-14

[17] Peterson K, Anderson J, Bourne D, Mackey K, Helfand M. Evidence Brief: Effectiveness of Models Used to Deliver Multimodal Care for Chronic Musculoskeletal Pain. VA Evidence-based Synthesis Program Evidence Briefs. *J Gen Intern Med.* 2018;33(Suppl 1):71-81

Adopted March 2017 | Approved by HCA April 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Behavioral-Health-Integration-Final-Recommendations-2017-03.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/behavioral-health/
    - Workgroup met from April 2016 to March 2017.
- **Background**
    - Approximately 16-23% of Americans experience a major depressive episode in their lifetimes, 7.6% in any two-week period.[18,19,20] Depression is especially common among those with a chronic illness, resulting in lower adherence to clinical recommendations, worse physical functioning, and higher cost.[21] Barriers to care include greater stigma attached to mental health and substance abuse diagnoses than for other conditions; a less developed infrastructure for measuring and improving care quality; lack of connectivity between clinicians, specialists, and organizations; lower use of health information technology; and coverage.[22]
- **Our recommendations**
    - Focused on integrating behavioral health care services into primary care for those with behavioral health concerns and diagnoses for whom accessing services through primary care would be appropriate. The workgroup defined integrated behavioral health care to create a common vocabulary as a minimum standard of care:
        - Integrated care team
        - Patient access to behavioral health as a routine part of care
        - Accessibility and sharing of patient information
        - Practice access to psychiatric services
        - Operational systems and workflows to support population-based care
        - Evidence-based treatments
        - Patient involvement in care
        - Data for quality improvement
- **Implementation**

[18] National Institutes of Mental Health. Major Depression Among Adults. www.nimh.nih.gov/health/statistics/prevalence/major-depression-among-adults.shtml. Published August 2015. Accessed May 2016.

[19] Kessler RC, Berglund P, Demler O, Jin R, Koretz D, Merikangas KR, Rush AJ, Walters EE, Wang PS and Replication, National Comorbidity Survey. The epidemiology of major depressive disorder: results from the National Comorbidity Survey Replication (NCS-R). *JAMA*.2003;289(23), pp. 3095-105.

[20] National Center for Health Statistics. FastStats Homepage Depression. Centers for Disease Control and Prevention. http://www.cdc.gov/nchs/fastats/depression.htm. Published April 2016. Accessed May 2016.

[21] Ciechanowski PS, Katon WJ, Russo JE. Depression and diabetes: impact of depressive symptoms on adherence, function, and costs. *Arch Intern Med*. 2000;160(21):3278-85.

[22] Institute of Medicine (US) Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders. *Improving the Quality of Health Care for Mental and Substance-Use Conditions*. Washington, D.C. National Academies Press; 2006.

- Bree Collaborative standards for integrating behavioral health into primary care to inform the development of required Accountable Communities of Health projects under the Medicaid Transformation Project.
- Bree Collaborative staff are also working to integrate behavioral health into primary care, see implementation section previously.
- Statewide in 2019, of adults with an identified mental health service need, 43% on commercial insurance received at least one qualifying service, 49% for Medicaid; 65% and 68% for children. For adults with a new diagnosis of depression, 66% stayed on antidepressant for 12 weeks post diagnosis, 46% at six months; 51% and 34% for those on Medicaid. Source: Washington Health Alliance. Washington Community Checkup. www.wacommunitycheckup.org.

Adopted November 2014 | Approved by HCA in December 2014

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/EOL-Care-Final-Report.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/eol/
    - Workgroup met from January to November 2014.
- End-of-life care in the United States and within Washington State is strikingly variable and often misaligned with patient preference.[23,24] Although the majority of patients report wanting to spend the last part of their lives at home, in reality much of this time is spent in a hospital or nursing home.[25]
- **Our recommendations**
    - The workgroup's goal that all Washingtonians are informed about their end-of-life care options, communicate their preferences in actionable terms, and receive end-of-life care that is aligned with their and their family members' goals and values.
    - **Focus areas**
        - Increase awareness of advance care planning, advance directives, and Physician Orders for Life-Sustaining Treatment (POLST)
        - Increase the number of people who participate in advance care planning in clinical and community settings
        - Increase the number of people who record their wishes and goals for end-of-life care using documents that accurately represent their values, are easily understandable by all readers (including family members, friends, and health care providers), and can be acted upon in the health care setting
        - Increase the accessibility of completed advance directives and POLST for health systems and providers
        - Increase the likelihood that a patient's end-of-life care choices are honored
- **Implementation and Outcomes**
    - The 2016 implementation survey indicates high rates of adoption of the recommendations among hospitals and medium rates among medical groups and health plans.
    - Advance care planning conversations are reimbursable by Medicaid in clinical settings. Private health plans including Premera, Regence, and others have been reimbursing for advance care planning conversations since January 2016.
    - HCA has incorporated recommendations for advance care planning in primary and hospital care into the PEBB Program Accountable Care Network contracts.
    - In 2020, Honoring Choices® Pacific Northwest (HCPNW) celebrates five years as a joint initiative between the Washington State Hospital Association and the Washington State Medical Association Foundation. Since inception, HCPNW has built

[23] Barnato AE, Herndon MB, Anthony DL, Gallagher PM, Skinner JS, Bynum JP, Fisher ES. Are regional variations in end of life care intensity explained by patient preferences? A Study of the US Medicare Population. *Med Care.* 2007;45(5):386-93.

[24] Goodman DC, Esty AR, Fisher ES, Chang CH. Trends and Variation in End of life Care for Medicare Beneficiaries with Severe Chronic Illness. The Dartmouth Atlas Project. www.dartmouthatlas.org/downloads/reports/EOL_Trend_Report_0411.pdf. Published April 2011. Accessed March 2014.

[25] Raphael C, Ahrens J, Fowler N. Financing end of life care in the USA. *J R Soc Med.* 2001; 94(9): 458–461.

resources in health care and community organizations to ensure that everyone receives care at the end of life which honors personal values and preferences. To date, nearly 21,000 meaningful advance care planning (ACP) activities, from individual conversations to group presentations, have taken place in settings as diverse as at the hospital bedside, in local churches, and online. A total of 55 teams (42 health care, 13 community) embed ACP work as program partners; 3 allies augment the work by boosting messaging to the community at large and hosting events for HCPNW to directly engage with the public. This year, HCPNW hosted its third successful conference, gathering diverse perspectives to discuss ACP through a variety of ways, including a commissioned play performed by The Grief Dialogues. HCPNW also responded to the COVID-19 pandemic; HCPNW presented a webinar series where leaders like Dr. Anthony L. Back discussed ACP in relation to COVID-19, created boot camps so ACP providers could be equipped to lead remote ACP sessions, and participated in a Respecting Choices national recording on how to provide virtual ACP services. Additionally, HCPNW responded to the Black Lives Matters movement by acknowledging how our ACP work has failed Black, Indigenous and People of Color (BIPOC) and will be enacting changes to confront racism at the end of life. More information about HCPNW's work can be found at their website, Twitter feed, or Facebook page.

Adopted January 2018 | Approved by HCA February 2018

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Hysterectomy-Final-Report-2018.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/hysterectomy/
    - Workgroup met from March 2017 to January 2018.
- **Background**
    - Hysterectomy is one of the most common surgical procedures in the United States, with approximately 600,000 performed annually.[26] Hysterectomy rates are highly variable by hospital and by region, indicating overuse.[27] Washington Health Alliance analysis reveals that rates are also highly variable based on location in Washington State.[28]
- **Our recommendations**
    - The workgroup's goal is to promote appropriate use of hysterectomy, including pre-surgical counseling and evaluation, while recognizing individual variation based on clinical opinion and patient preference. Workgroup members developed the recommendations to encourage clinicians to review guidelines with patients prior to surgery to reduce unnecessary or inappropriate hysterectomies.
    - The recommendations are applicable for uterine leiomyoma (fibroids), abnormal menstrual bleeding, endometriosis, uterine prolapse, adenomyosis, and pain. For each of the inclusions, the workgroup has developed protocols for assessment, medical management, and uterine sparing procedures.
    - The recommendations exclude pregnancy, cancer and cancer prevention, emergencies (e.g., due to trauma, childbirth), gender reassignment surgery, and incidental hysterectomy with indicated oophorectomy.
    - **Focus Areas**
        - Assessment and medical management, by indication
        - Uterine sparing procedures, by indication
        - Surgical procedure including follow-up care, emphasizing the enhanced recovery after surgery protocol and use of a minimally invasive approach. The Enhanced Recovery After Surgery (ERAS) protocol fits well with gynecological surgery and has been associated with reduced opioid use, length of stay, and cost; stable readmission; incidence of side effects; and improved patient satisfaction.[29,30]
- **Implementation and Outcomes**

[26] Wu JM, Wechter ME, Geller EJ, Nguyen TV, Visco AG. Hysterectomy rates in the United States, 2003. *Obstet Gynecol*. 2007;110(5):1091-5.
[27] Wennberg J, Gittelsohn. Small area variations in health care delivery. Science. 1973;182(4117):1102-8.
[28] Washington Health Alliance. Different Regions, Different Health Care: Where you Live Matters. Washington Health Alliance;2015. https://wahealthalliance.org/wp-content/uploads/2015/01/Different-Regions-Different-Care.pdf. Published January 2015. Accessed August 8, 2015.
[29] Nelson G, Altman AD, Nick A, Meyer LA, Ramirez PT, Achtari C, Antrobus J, Huang J, et al. Guidelines for pre- and intra-operative care in gynecologic/oncology surgery: Enhanced Recovery After Surgery (ERAS®) Society recommendations--Part I. *Gynecol Oncol*. 2016;140(2):313-22.
[30] Kalogera E, Bakkum-Gamez JN, Jankowski CJ, Trabuco E, Lovey JK, Dhanorker S, et al. Enhanced Recovery in Gynecologic Surgery. *Obstet Gynecol.* 2013;122(2):319–28.

- Infections from hysterectomy occur in 0.42% of cases in Washington State. Blood clots developed and no preventative treatment was provided in 4% of cases (3% nationally), and serious complications occurred in 1% of surgeries (1% nationally). Source: Washington State Hospital Association. WA Hospital Quality. www.wahospitalquality.org/

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/LGBTQ-Health-Care-Report-and-Recommendations01.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/previous-topics/lgbtq-health-care/
    - Workgroup met from December 2017 to September 2018.
- **Background**
    - Building a health care system that allows everyone to have a fair opportunity to be healthier is a goal across Washington State. Approximately 3.5% of Americans identify as lesbian, gay, or bisexual and 0.3% of American adults are transgender. LGBTQ people share common challenges and have health care needs distinct from those who do not identify as LGBTQ.[31] While all people share baseline health care needs, the LGBTQ population is also at a higher risk for specific medical problems.[32] Those who identify as LGBTQ are diverse and from many socioeconomic backgrounds, races, ethnicities, and cultures. Disparities can be magnified when LGBTQ persons are also part of a racial or ethnic minority, a fact important to policy initiatives and clinical care.[33]

- **Our recommendations**

    - The goal is to align care delivery with existing evidence-based, culturally sensitive standards of care for LGBTQ people in Washington State and through that effort to decrease health disparities. The workgroup based recommendations in a whole-person care framework, taking into consideration a person's multiple individual factors that make up health, wellness, and experience (e.g., behavioral health, past trauma, race/ethnicity) in such a way that is not identity or diagnosis-limiting. We organize the recommendations under three focus areas:
        - Communication, Language, and Inclusive Environments
        - Screening and Taking a Social and Sexual History
        - Areas Requiring LGBTQ-Specific Standards and Systems of Care
    - All health care encounters should occur using non-judgmental, non-stigmatizing language, body language, and tone.

[31] Purcell DW, Johnson CH, Lansky A, et al. Estimating the population size of men who have sex with men in the United States to obtain HIV and syphilis rates. *Open AIDS J.* 2012; 6(1):98-107.
[32] Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding.* Washington, D.C.: National Academies Press; 2011. Summary.
[33] Buchmueller T, Carpenter CS. Disparities in health insurance coverage, access, and outcomes for individuals in same-sex versus different-sex relationships, 2000-2007. *Am J Public Health*. 2010;100(3):489-95.

LOW BACK PAIN AND SPINE SURGERY

Adopted November 2013 | Approved by HCA January 2014

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/spine_lbp.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/spine/
  - Workgroup met from November 2012 to October 2013.
- **Our recommendations**
  - Appropriate evaluation and management of patients with new onset and persistent acute low back pain and/or nonspecific low back pain not associated with major trauma (no red flags) in primary care
  - Early identification and management of patients that present with low back pain not associated with major trauma (no red flags) but have psychosocial factors (yellow flags) that place them at a high risk for developing chronic low back pain
  - Awareness of low back pain management among individual patients and the general public
- **Implementation and Outcomes**
  - The 2016 implementation survey found high rates of adoption of the recommendations among hospitals and low rates among medical groups and health plans.
  - The Washington Health Alliance reports a 2019 statewide rate for avoiding X-ray, magnetic resonance imaging (MRI), and computed tomography (CT) for low-back pain of 82% for commercial insurance (81% in 2017) and 74% for Medicaid (76% in 2017).[34]
- **Community Partner: Spine Surgical Care and Outcomes Assessment Program**
  - In March 2013, the Bree Collaborative submitted recommendations to HCA strongly recommending participation in Spine COAP as a community standard and requiring that information be transparent.
  - Implementation
    - As of spring 2020, 16 hospitals are enrolled in Spine SCOAP.
    - As of August 2014, length of stay, radiologic verification of surgical level, and smoking use have been transparently available on the Spine SCOAP website.

[34] Washington Health Alliance. Community Checkup. www.wacommunitycheckup.org/compare-scores/compare-results/. Updated 2020. Accessed March 2020.

Adopted January 2020

- **Read the report here:** www.breecollaborative.org/wp-content/uploads/Maternity-Bundle-FINAL-2020.pdf
- **Learn more about our workgroup here:** www.breecollaborative.org/topic-areas/previous-topics/maternity-bundle/
    - Workgroup met from January 2019 – January 2020 and is planning another meeting in July 2020 to consider adding pediatric care to the bundle.
- Background
    - The United States has the highest maternal death rate among developed nations with more than 50,000 mothers having life-threatening complications annually.[35,36] Mortality also differs greatly based on race with black mothers being three to four times as likely to die in childbirth than white mothers.[6,8] Black mothers are more likely to suffer complications that lead to injury.[6,37] Further, childbirth is the single largest cost for state Medicaid and also most commercial health plans.[38]
    - Bundled payment models can address some of these preventable complications and various models are currently being used across the country.[39] Many of these models cover low-risk pregnancies, limiting their impact on health equity while others exclude the highest and lowest cost episodes and select conditions.[5,40]
- **Our Bundle**
    - The workgroup developed a clinical pathway supported by an episode-based payment model. The pathway builds on existing perinatal work within Washington State that includes prenatal care, labor and delivery, and postpartum care. The greatest areas of impact include cardiovascular disease screening and intervention, behavioral health screening and treatment, continued engagement with care postpartum (especially for substance use disorder), support of a low-intervention birth[41], and more individualized, frequent postpartum visits. The workgroup is prioritizing health

[35] Centers for Disease Control and Prevention. Pregnancy-Related Deaths. www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-relatedmortality.htm. Published February 2019. Accessed February 2019.

[36] Save the Children. State of the World's Mothers 2015. www.savethechildren.org/content/dam/usa/reports/advocacy/sowm/sowm-2015.pdf. Published January 2015. Accessed February 2019.

[37] Tucker MJ, Berg CJ, Callaghan WM, Hsia J. The Black-White disparity in pregnancy-related mortality from 5 conditions: differences in prevalence and case-fatality rates. *Am J Public Health*. 2007;97(2) 247-51.

[38] Center for Healthcare Quality and Payment Reform. How to Save $5 Billion in Healthcare Spending for Employers and Taxpayers. http://chqpr.org/blog/index.php/2013/01/how-to-save-5-billion-in-healthcare-spending-for-employers-and-taxpayers/. Published January 2013. Accessed May 2019.

[39] HCP-LAN Maternity Multi-Stakeholder Action Collaborative. Issue Brief: The Business Case for Maternity Care Episode-Based Payment. http://hcp-lan.org/workproducts/MAC-maternity-care-VBP-business-case-03-20-2017.docx. Published March 2017. Accessed March 2019.

[40] New York State Department of Health. Maternity Care Clinical Advisory Group Value Based Payment Recommendation Report. www.health.ny.gov/health_care/medicaid/redesign/dsrip/vbp_library/2016-06-03_maternity_rpt.htm#desc. Published May 2016. Accessed May 2019.

[41] American College of Nurse-Midwives. Supporting Healthy and Normal Physiologic Childbirth: A Consensus Statement by ACNM, MANA, and NACPM. *J Midwifery Women's Health.* 2012;57(5):529–32. doi:10.1891/1058-1243.22.1.14.

equity, high-quality and evidence-based perinatal and pediatric care, and inclusive criteria defined as:

- Beginning 270 days prior to delivery and ending 84 days (3 months) post-delivery. The workgroup's ideal is to implement a perinatal bundle that will last 365 days (12 months) post-delivery (total 635 days).
- Including prenatal care, labor and delivery, and postpartum services for both facility and professional services.
- Designating the obstetric care provider as the accountable entity.

Adopted August 2012 | Approved by HCA October 2012

- **Read the report here:** www.breecollaborative.org/wp-content/uploads/bree_ob_report_final_080212.pdf
- **Learn more about our workgroup here:** www.breecollaborative.org/topic-areas/obcare/
  - Workgroup met from December 2011 to July 2012
- **Our recommendations**
  - Elective deliveries. Eliminate all non-medically necessary early elective deliveries before the 39th week (those deliveries for which there is no appropriate documentation of medical necessity for early elective delivery).
  - Elective inductions of labor. Decrease elective inductions of labor between 39 and up to 41 weeks.
  - Primary Cesarean-sections (C-sections). Decrease unsupported variation among Washington hospitals in C-section rate of women who have never had a C-section.
- **Implementation and Outcomes**
  - HCA has implemented a non-payment policy for early elective deliveries for Medicaid.
  - The 2016 implementation survey found high rates of recommendation adoption among hospitals and medical groups:
    - 0 -No action taken; 1 -Actively considering adoption; 2 -Some/similar adoption; and 3 -Full adoption
      - Hospital average: 2.8 Range: 1.9-3.0
      - Medical Group average: 2.8 Range: 2.4-3.0
      - Health Plan average: 2.0 Range: 1.0-3.0
  - The Safe Deliveries Roadmap (SDR) program partners with all 58 Washington non-military birthing hospitals in improving maternal and infant health outcomes through innovative programs combining data collection, analysis and reporting, monthly education from subject matter experts, peer to peer coaching calls, in-person learning collaboratives, implementation of evidence-based best practices and hospital site visits. During site visits SDR staff review hospital data, identify areas of success and discuss opportunities.

Adopted March 2016 | Approved by HCA in April 2016

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Oncology-Care-Final-Recommendations-2016-03.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/oncology-care/
    - Workgroup met from May 2015 to March 2016.
- While cancer death rates have declined due in part of advances in prevention and treatment, cost of care has increased significantly, resulting in financial burden on patients and families.[42] Cost and quality can also vary, indicating the need for greater standardization and reduction in procedures that do not result in better patient health.[43,44] In 2012, the American Society of Clinical Oncology (ASCO) identified five tests or procedures "whose necessity is not supported by high-level evidence" and developed guidelines around therapeutic effectiveness and palliative care and use of advanced imaging for staging of low risk breast and prostate cancer.[45]
- **Our recommendations:**
    - As part of Choosing Wisely, ASCO recommends:
        - Do not use PET [positron emission tomography], CT [computed tomography] and radionuclide bone scans in the staging of early prostate cancer at low risk of spreading.
        - Do not use PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk of spreading.
    - In alignment with the End-of-Life Care Recommendations, oncology care should be aligned with a patient's individual goals and values. Patients should be appraised of harms, benefits, evidence, and potential impact of chemotherapy and radiation at all stages in illness trajectory and should regularly discuss goals of care and work to tailor care to goals.
- **Implementation and Outcomes**
    - The 2016 implementation survey found high rates of adoption for hospitals and medical groups.

[42] Kohler BA, Sherman RL, Howlader N, Jemal A, Ryerson AB, Henry KA, Boscoe FP, Cronin KA, Lake A, Noone AM, Henley SJ, Eheman CR, Anderson RN, Penberthy L. Annual Report to the Nation on the Status of Cancer, 1975-2011, Featuring Incidence of Breast Cancer Subtypes by Race/Ethnicity, Poverty, and State. *J Natl Cancer Inst.* 2015;107(6):djv048.

[43] Kolodziej M, Hoverman JR, Garey JS, Espirito J, Sheth S, Ginsburg A, et al. Benchmarks for Value in Cancer Care: An Analysis of a Large Commercial Population. *JOP*. 2011;7(5):301-306.

[44] Schroeck FR, Kaufman SR, Jacobs BL, Skolarus TA, Hollingsworth JM, Shahinian VB, Hollenbeck BK. Regional variation in quality of prostate cancer care. *J Urol*. 2014;191(4):957-62.

[45] Schnipper LE1, Smith TJ, Raghavan D, Blayney DW, Ganz PA, Mulvey TM, Wollins DS. American Society of Clinical Oncology identifies five key opportunities to improve care and reduce costs: the top five list for oncology. *J Clin Oncol*. 2012;30(14):1715-24.

OPIOID PRESCRIBING

This is an ongoing workgroup focused on implementing the Washington State Agency Medical Directors Guideline on Prescribing Opioids for Pain, endorsed by the Bree Collaborative in July 2015. The information below profiles the workgroup's products from December 2015 to October 2018. Two primary focus areas have been to develop opioid prescribing metrics and a guideline on prescribing opioids in dentistry.

Learn more about the workgroups here: www.breecollaborative.org/topic-areas/opioid/

OPIOID PRESCRIBING METRICS

Adopted August 2017 | Approved by HCA August 2017

- **See the Opioid Prescribing Metrics here:** www.breecollaborative.org/wp-content/uploads/Bree-Opioid-Prescribing-Metrics-Final-2017.pdf
- The metrics were designed to be limited in number, have a strategic focus, and to be used for quality improvement. The first six metrics focus on guideline-concordant prescribing including chronic opioid use, opioid dose, concurrent chronic sedative use, and transition from short-term to long-term opioid use. The last three metrics focus on mortality, overdose morbidity, and prevalence of opioid use disorder.
- One of the primary goals of this metric set is to be short and actionable. The workgroup discussed other potential metrics that are of high interest but are not yet ready for specification and implementation and are out of the scope of a workgroup focused on prescribing practices. These and other metrics may be developed at a future date. Outreach to the Washington State health care community to adopt the metrics is ongoing.
- **Implementation and Outcomes**
    - All metrics are being used by the Washington State Department of Health with a dashboard by county that is available using data from the Prescription Monitoring Program at the WA State Department of Health. www.doh.wa.gov/DataandStatisticalReports/HealthDataVisualization/OpioidPrescriptionsandDrugOverdosesCountyData. Rates shown below are per 1000 showing change from quarter 1 2012 to quarter 4 2019
        - Any opioid prescription decreased to 57.2 from 88.9 per 1000
        - Chronic opioid prescription decreased to 15.2 from 18.9 per 1000
        - High-dose chronic opioid prescriptions >50MME decreased to 4.7 from 8.3 per 1000
        - Concurrent opioid and sedative prescriptions decreased to 8.9 from 18.4 per 1000
    - Three metrics (i.e., new opioid patients transitioning to chronic opioids, patients prescribed high-dose chronic opioid therapy, new opioid patients' days' supply of first opioid prescription) have been adopted and will be included in the State Common Measure Set by the Performance Measures Coordinating Committee.
    - HCA has implemented opioid prescribing policy consistent with Bree recommendations in Medicaid and Uniform Medical Plan.
    - The Oregon Health Authority has added the definition for percent of patients transitioning from acute to chronic opioid prescribing to their dashboard.

DENTAL GUIDELINE ON PRESCRIBING OPIOIDS FOR PAIN

Adopted September 2017 | Approved by HCA October 2017

- **Read the guideline here:** www.breecollaborative.org/wp-content/uploads/Dental-Opioid-Recommendations-Final-2017.pdf
- The guideline was developed in collaboration with a broad advisory group of academic leaders, pain experts, and dentists in general care and specialty areas in response to the growing epidemic of opioid-related overdoses. The guideline supplements the Agency Medical Director's Group (AMDG) Interagency Guideline on Prescribing Opioids for Pain. Work will continue to encourage adoption of the recommendations.
- **Implementation and Outcomes**
    - The Department of Labor and Industries held multiple conferences in Spokane and Seattle in 2018 to educate the dental community about the guidelines.

PERIOPERATIVE OPIOID PRESCRIBING

Adopted July 2018 | Approved by HCA August 2018

- See the Perioperative Opioid Prescribing Guideline here: www.breecollaborative.org/wp-content/uploads/Final-Supplemental-Bree-AMDG-Postop-pain-091318-wcover.pdf
- The included evidence represents a rapidly evolving literature on appropriate postoperative opioid prescribing. The recommendations in this supplement are based on the current best available clinical and scientific evidence from the literature and a consensus of expert opinion, and should be seen as an addition to, rather than a replacement of, the guidelines for opioid prescribing for postoperative pain in the 2015 guideline.
- For all surgery types, we recommend the clinician prescribe non-opioid analgesics (e.g., nonsteroidal anti-inflammatory drugs (NSAIDs), acetaminophen, and non-pharmacologic therapies as first line therapy. Rationale for any exceptions should be well documented in the record. Even in these exceptions the initial prescription should not exceed two weeks. Bree classifications are constructed around evidence to date to serve as a guide for procedures with similar degrees of expected post-op pain and include:
    - People younger than 24 years old. Dental extractions (e.g., third molar, wisdom tooth removal)
    - Adults
        - Type I – Expected rapid recovery: dental extractions or simple oral surgery (e.g., graft, implant); procedures such as hernia repair, etc.
        - Type II –Expected medium term recovery: Procedures such as ACL repair, rotator cuff repair, etc.
        - Type III – Expected longer term recovery: Procedures such as lumbar fusion, knee replacement, etc.
        - Patients on Chronic Opioid Analgesic Therapy

CLINICIAN OUTREACH

- **See the Guidelines on Prescribing Opioids for Acute Pain for Providers fact sheet:** wahealthalliance.org/wp-content/uploads/2017/01/Opioid-Prescribing-Guidelines-for-Providers.pdf

- **See Opioid Medication and Pain: What You Need to Know fact sheet for patients:** wahealthalliance.org/wp-content/uploads/2017/01/Opioid-Medication-Pain-Fact-Sheet-revised.pdf
- The Bree Collaborative partnered with the Washington Health Alliance to develop a call to action for health care systems and for health insurance plans to follow responsible opioid prescribing coupled with fact sheets for providers and for patients aligned with AMDG Opioid Prescribing Guidelines.
- These materials were made available online and through dissemination to health systems, hospitals, and plans in January 2017.
- **Implementation and Outcomes**
    - HCA shared joint Bree Collaborative/Washington Health Alliance communications about opioid prescriptions with providers and patients.
    - The State of Alaska Department of Health and Social Services has adopted the fact sheets for their community and are using the materials widely.
    - Seattle King County Department of Health has posted the fact sheets on their website and translated them into 21 languages here: www.kingcounty.gov/depts/community-human-services/mental-health-substance-abuse/task-forces/heroin-opiates-task-force.aspx#documents

LONG-TERM OPIOID THERAPY

Adopted May 2020

- See the Long-Term Opioid Therapy: www.breecollaborative.org/wp-content/uploads/Bree-Long-Term-Opioid-Use-Recommendations-FINAL-20-05.pdf
- This workgroup met from December 2018 to April 2020.
- Held a conference on August 9, convening national experts to discuss the state of the science for people who have been prescribed opioids chronically.
- Recommendations
    - For all patients, care should be individualized and thoughtful. Care should focus on improved function, increased quality of life, and greater patient autonomy rather than a primary focus on pain relief (as this may not be realistic for many people). Opioids should not be suddenly discontinued.[46]
        - Patient engagement: Build a trusting relationship. Start by engaging the patient in care, discussing their goals (e.g., "what are your expectations," "what do you hope to accomplish"), preferences, and needs.
        - Assessment: Complete a history and directed physical exam as indicated including pain-related diagnoses and past experiences with pain interventions. Assess functional status. Behavioral health screening and referral (i.e., depression, anxiety, suicidality, alcohol and drug use).

[46] US Food and Drug Administration. FDA Drug Safety Communication: FDA identifies harm reported from sudden discontinuation of opioid pain medicines and requires label changes to guide prescribers on gradual, individualized tapering. www.fda.gov/drugs/drug-safety-and-availability/fda-identifies-harm-reported-sudden-discontinuation-opioid-pain-medicines-and-requires-label-changes. Updated April 2019 Accessed April 2019.

- Develop a treatment plan: Treatment plans should be developed in collaboration with the patient, and family or others if appropriate. Treat opioid use disorder, if present, using evidence-based protocols including medication-assisted treatment (MAT). Review non-opioid management of chronic pain.

Adopted November 2017 | Approved by HCA December 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/OUD-Treatment-Final-2017.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/oud-treatment/
    - Workgroup met from December 2016 to November 2017.
- **Background**
    - Drug overdose is the leading cause of accidental death in the United States, driven predominantly by opioid addiction.[47] Among those under 50 years of age, drug overdose is the leading cause of death. In 2016, the number of annual deaths by drug overdose increased 19% over the previous year to exceed 59,000.[48] High schoolers who receive only one opioid prescription are 33% more likely than those who do not receive such a prescription to misuse opioids between the ages of 18-23 years.[49]
- **Our recommendations**
    - The workgroup's goal is a health care system that identifies people with opioid use disorder and facilitates access to comprehensive, evidence-based treatment with the patient at the center of care. This approach works to ensure that care is available when a patient is ready.
    - The workgroup endorses a "no wrong door" approach for patients wanting to access opioid use disorder treatment from a variety of settings. To support this, the workgroup developed recommendations to guide providers delivering care within a variety of settings. The goal for all settings is that patients receive the care they need

[47] American Society of Addiction Medicine. Opioid Addiction 2016 Facts and Figures. http://www.asam.org/docs/default-source/advocacy/opioid-addiction-disease-facts-figures.pdf Accessed November 2016.

[48] Katz, J. Drug Deaths in America Are Rising Faster Than Ever. *The New York Times.* 2017; www.nytimes.com/interactive/2017/06/05/upshot/opioid-epidemic-drug-overdose-deaths-are-rising-faster-than-ever.html?rref=collection%2Fsectioncollection%2Fupshot&action=click&contentCollection=upshot&region=rank&module=package&version=highlights&contentPlacement=4&pgtype=sectionfront&_r=0. Published December 2015. Accessed November 5, 2017

[49] Miech R, Johnston L, O'Malley PM, et al. Prescription opioids in adolescence and future opioid misuse. *Pediatrics.* 2015; 136(5):e1169-77.

at the time and in the setting of their choice, reduce illicit opioid use, and have no overdose events.

- **Focus areas**
  - Access to Evidence-Based Treatment
    - Medication treatment: buprenorphine, methadone, naltrexone (e.g., increase geographic reach, increase number of providers)
    - Reduction in stigma associated with treatment
  - Referral Information
    - Providers and patients know where to access care
    - Accessible inventory of buprenorphine and methadone prescribers
    - Referral infrastructure that supports patients and providers
  - Integrated Behavioral and Physical Health to Support Whole-Person Care
    - Treatment of comorbid conditions including multiple substance use, mental illness, and physical health in line with Behavioral Health Integration Report and Recommendations

PEDIATRIC PSYCHOTROPIC USE

Adopted November 2016 | Approved by HCA January 2017

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Antipsychotic-Recommendations-Final-2016.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/psychotropics/
  - Workgroup met from January to November 2016.
- **Background**
  - Antipsychotic prescribing rates have dramatically and consistently increased for adolescents and young adults.[50] Nationally, between 2002 and 2007, there has been a 62% increase in atypical antipsychotic (or second-generation) use among children enrolled in Medicaid.[51] High numbers of prescriptions are problematic and potentially harmful and lacks long-term study.[52]
  - The United States Food and Drug Administration (FDA) has approved antipsychotic medications for use in children and adolescents with schizophrenia, bipolar disorder (manic/mixed), and irritability with autistic disorder. In addition to the FDA-approved indications, antipsychotics have been found to be helpful in reducing disruptive behavior in children and adolescents *without* psychosis, allowing the child or adolescent to remain in school, in home, and receptive to other forms of therapy. These off-label uses of antipsychotic agents (i.e., for conditions not approved by the FDA) include aggressive, impulsive, and disruptive behaviors, often in patients with attention-deficit hyperactivity disorder (ADHD), in the absence of psychosis.[53]
- **Our recommendations**
  - Targeted at children and adolescents under age 21 without a diagnosis of an FDA-approved indication for an antipsychotic prescription.
  - **Focus Areas**
    - Conduct initial medical and psychological evaluation using appropriate assessment
    - Ensure that the patient and family has access to comprehensive, family-centered psychosocial care whether within the primary care setting through integrated behavioral health care or through a supported referral
    - Use evidence-based, best practice antipsychotic prescribing recommendations such as from the American Academy of Child and Adolescent Psychiatry
    - If antipsychotics are prescribed, manage side effects including monitoring for changes in weight blood glucose (HgA1C), cholesterol, and other metabolic changes (baseline and at regular intervals)

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[50] Birnbaum ML, Saito E, Gerhard T, Winterstein A, Olfson M, Kane JM, Correll CU. Pharmacoepidemiology of antipsychotic use in youth with ADHD: trends and clinical implications. *Curr Psychiatry Rep*. 2013 Aug;15(8):382.

[51] Matone M, Localio R, Huang YS, dosReis S, Feudtner C, Rubin D. The relationship between mental health diagnosis and treatment with second-generation antipsychotics over time: a national study of U.S. Medicaid-enrolled children. *Health Serv Res*. 2012 Oct;47(5):1836-1860.

[52] Seida JC, Schouten JR, Mousavi SS, Hamm M, Beaith A, Vandermeer B, et al. *First- and Second Generation Antipsychotics for Children and Young Adults*. Rockville, MD: Agency for Healthcare Research and Quality; 2012. 11(12)/EHC077-EF.

[53] Olfson M, King M, Schoenbaum M. Treatment of Young People With Antipsychotic Medications in the United States. *JAMA Psychiatry*. 2015;72(9):867-874.

- **Implementation and Outcomes**
    - The state average for generic medications for ADHD is 78% for commercial coverage and 83% for Medicaid; for follow-up care provided for children prescribed ADHD medication within nine months it is 41% for commercial and 36% for Medicaid.

POTENTIALLY AVOIDABLE HOSPITAL READMISSIONS

Adopted July 2014 | Approved by HCA in August 2014.

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Readmissions-Report-FINAL-14-0730.pdf
- **Read the 30-day, all-cause re-hospitalization rates at Washington State hospitals data here:** www.breecollaborative.org/wp-content/uploads/combined-chars-report-13-1114.pdf
- **Learn more about the workgroup here:** www.breecollaborative.org/topic-areas/par/
    - The workgroup met from April to June 2014.
- **Our recommendations:**
    - Forming Collaboratives: Hospital readmissions collaboratives to be recognized by a formal charter, meeting participation, and recognition by WSHA or Comagine Health (previously Qualis Health)
    - Toolkit: Support for the tools and techniques to reduce readmissions in Washington State, especially the WSHA's *Care Transitions Toolkit, second edition*, the work done by Qualis Health, and the work done by the Washington Health Alliance
    - Measurement: Two hospital-specific measures aligned with the Medical Quality Incentive Program measured by WSHA for specific conditions for (a) patient discharge information to primary care provider and (b) documented follow-up phone call
- **Implementation and Outcomes**
    - The 2016 implementation survey found medium rates of adoption of the recommendations among hospitals and high rates among medical groups and health plans.
    - Rates for hospital-specific measures including readmissions in general and readmissions for specific conditions as compared to the national average and previous year are as follows: all-cause 14.5% (15.3% nationally, 14.4% previous year); heart attack 15.2% (15.7% nationally, 15.3% previous year); heart failure 20.6% (21.6% nationally, 20.8% previous year); pneumonia 15.8% (16.6% nationally,15.9% previous year); hip and knee replacement 3.8% (4% nationally, 3.8% previous year). Source: Washington State Hospital Association. WA Hospital Quality. www.wahospitalquality.org/

PROSTATE CANCER SCREENING

Adopted November 2015 | Approved by HCA in January 2016

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Prostate-Cancer-Recommendations-Final-15-11.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/prostate-cancer-screening/
    - Workgroup met from March to November 2015.
- Prostate cancer is the most common type of cancer diagnosed among men.[54] The prostate specific antigen (PSA) test is commonly used to screen men for prostate cancer. However, evidence conflicts as to whether the PSA test when used for prostate cancer screening has been associated with reduction in prostate cancer mortality.[55,56] The potential for overtreatment or treatment when no disease is present is high.[57]
- **Our recommendations:**
    - All men be evaluated by their provider for family history and factors that may elevate the risk of prostate cancer (e.g., sibling or parent with a prostate or breast cancer diagnosis, race).
    - To refrain from routine screening with PSA testing for average risk men 70 years and older, under 55 years old, who have significant co-morbid conditions, or with a life expectancy less than 10 years.
    - For primary care clinicians, two possible pathways, depending on the physician's interpretation of the evidence.
        - Clinicians who believe there is overall benefit from screening with PSA testing should order this test for average risk men between 55-69 years old only after a formal and documented shared decision-making process.
        - Clinicians who believe there is overall harm from screening with PSA testing may initiate testing of average-risk men aged 55-69 at the request of the patient after a formal and documented shared decision-making process.
    - Only men who express a definite preference for screening after discussing the advantages, disadvantages, and scientific uncertainty should have screening with PSA testing.
- **Implementation and Outcomes**
    - The 2016 implementation survey found high rates of adoption for hospitals, medium rates for medical groups, and low rates for health plans.

[54] Siegel R, Ma J, Zou Z, Jemal A. *Cancer statistics, 2014*. CA Cancer J Clin. 2014. 9-29/64/5.
[55] Schröder FH, Hugosson J, Roobol MJ, Tammela TL, Zappa M, Nelen V, et al. Screening and prostate cancer mortality: results of the European Randomised Study of Screening for Prostate Cancer (ERSPC) at 13 years of follow-up. *Lancet*. 2014;384(9959):2027-35.
[56] Andriole GL, Crawford ED, Grubb RL 3rd, Buys SS, Chia D, Church TR, et al. Prostate cancer screening in the randomized Prostate, Lung, Colorectal, and Ovarian Cancer Screening Trial: mortality results after 13 years of follow-up. J Natl Cancer Inst. 2012 Jan 18;104(2):125-132.
[57] Gulati R, Inoue LY, Gore JL, Katcher J, Etzioni R. Individualized estimates of overdiagnosis in screen-detected prostate cancer. *J Natl Cancer Inst*. 2014 Feb;106(2):367

Adopted January 2020

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Recommendations-Risk-Violence-Others-FINAL-2020.pdf
- **Learn more about the workgroup:** www.breecollaborative.org/topic-areas/current-topics/risk-of-violence/
    - Workgroup met from January 2019 to January 2020.
- **Background**
    - Acts of interpersonal violence, especially homicide, while statistically rare, represent a high public health and clinical priority due to the potential for tragic outcomes. The vast majority of behavioral health patients are not violent. However, a small percentage of those with a behavioral health diagnosis may be at an increased risk for violence. Violent acts are more strongly associated with drug and alcohol use than a mental health diagnoses.[58]
    - The 1976 California Supreme Court Case decision *Tarasoff v Regents of the University of California* established therapists' duty to protect third parties from violent behavior of a patient.[59] The 2016 Washington State Supreme Court decision *Volk v DeMeerleer* held that a mental health professional who establishes a special relationship with a patient has a duty to protect any foreseeable victim from a patient's dangerous propensities.[60,61]
    - In 2018, the Washington State Legislature included a budget proviso for the Bree Collaborative to address the clinical uncertainty resulting from the 2016 Washington State Supreme Court *Volk v. DeMeerler* decision. This work builds upon the 2017 Collaborative recommendations to integrate behavioral health into primary care and the 2018 recommendations on suicide care.
- **Our Recommendations**
    - The workgroup is clear that clinicians can identify and monitor an individual's risk factors for violence, make a reasonable assessment based on those known risk factors, and make decisions for clinical management, but cannot predict violent acts with certainty. The workgroup is also concerned with setting actionable recommendations in light of the standards set out in the *Volk* decision. Notwithstanding those concerns, the workgroup prioritizes a patients' right to both confidentiality and also to care in the least restrictive environment, and recognizes the need to balance those priorities with the duty to protect the community. Documentation at each clinical decision point should be part of the clinical record.
    - **Focus areas**
        - Identification of increased risk for violence

[58] Swinson N, Flynn SM, While D, Roscoe A, Kapur N, Appleby L, Shaw J. Trends in rates of mental illness in homicide perpetrators. *Br J Psychiatry*. 2011;198(6):485-9.
[59] *Tarasoff v Regents of the University of California*, 17 Cal 3d 425 (1976).
[60] *Volk v DeMeerleer*, 187 Wn2d 241 (2016).
[61] Greenberg J. Volk v. DeMeerleer: An Unprincipled Duty. 92 Was L. Rev. Online 13. June 22, 2017. http://digital.law.washington.edu/dspace-law/bitstream/handle/1773.1/1696/92WLRO013.pdf?sequence=1&isAllowed=y . Accessed May 2019.

- Further assessment of violence risk
- Violence risk management
- Community protection

Adopted November 2019

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Recommendations-Shared-Decision-Making-FINAL-2019.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/previous-topics/shared-decision-making/
    - Workgroup met from January to November 2019.
- **Background**
    - Shared decision making is a key component of patient-centered care, "a process that allows patients and their providers to make health care decisions together, taking into account the best scientific evidence available, as well as the patient's values and preferences."[62] Shared decision making is appropriate for preference-sensitive conditions in which there is high-quality clinical evidence for more than one treatment, management option, or screening or where there is lack of evidence and no clinical consensus on the best option. This necessitates communication between a provider and patient, and in some cases family members or others, about risks, benefits, and exploration of values and goals. Unfortunately, involving patients as equal partners in health care decisions that have multiple clinically appropriate options by fully discussing risks and benefits remains limited within clinical practice. Barriers to implementing shared decision making into clinical practice include provider time; overwork; lack of training; lack of structural support, including through electronic health records and general workflow; fear of revenue loss; and decision aids not being available or applicable to a specific patient or clinical situation.[63,64]
    - HCA has worked to certify patient decision aids since April 2016.[65] Washington State law allows for shared decision making to meet enhanced informed consent standards and supports the shared decision making process.[66]
- **Our Recommendations**
    - The workgroup prioritized ten health conditions for which shared decision making is appropriate and categorized uptake of shared decision making within those areas. The overall goal is movement toward greater use of shared decision making in clinical practice; and that all clinical sites move towards action.
    - Focus areas:
        - A common understanding and shared definition of shared decision making and the benefit of shared decision making

[62] Washington State Health Care Authority. Shared Decision Making. www.hca.wa.gov/about-hca/healthier-washington/shared-decision-making. Published February 2018. Accessed: November 15, 2018.
[63] Gravel K, Légaré F, Graham ID. Barriers and facilitators to implementing shared decision-making in clinical practice: a systematic review of health professionals' perceptions. *Implement Sci.* 2006;1(16). doi:10.1186/1748-5908-1-16.
[64] Friedberg MW, Van Busum K, Wexler R, Bowen M, Schneider EC. A Demonstration Of Shared Decision Making In Primary Care Highlights Barriers To Adoption And Potential Remedies. *Health Aff (Millwood).* 2013;32(2):268-75.
[65] Washington State Health Care Authority. Patient Decision Aids (PDAs). 2018. www.hca.wa.gov/about-hca/healthier-washington/patient-decision-aids-pdas Published October 2018. Accessed December 4, 2018
[66] RCW 7.70.060. Consent form—Contents—Prima facie evidence—Shared decision making—Patient decision aid—Failure to use. https://app.leg.wa.gov/RCW/default.aspx?cite=7.70.060

- Ten priority areas as first steps for the health care community: Abnormal Uterine Bleeding, Advance Care Planning, Attention Deficit Hyperactivity Disorder Treatment, Cancer Screening, Depression Treatment, Herniated Disk, Knee and Hip Osteoarthritis, Opioid Use Disorder Treatment, Spine Surgery (Lumbar Fusion), Trial of Labor After Cesarean Section
- Highly reliable implementation using an existing framework customized to an individual organization
- Documentation, coding, and reimbursement structure to support broad use

Adopted September 2018 | Approved by HCA October 2018

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Suicide-Care-Report-and-Recommendations-Final.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/previous-topics/suicide-care/
    - Workgroup met from March 2017 to January 2018.
- **Background**
    - Suicide is both a preventable outcome and a public health issue.[67] The effect of a suicide on family members, friends, and clinical providers is long-lasting and profound.[68,69] Rates of suicide have increased in nearly every state from 1999 to 2016 with a 19% increase in Washington State.[70] Suicide is the second leading cause of death among those aged 15-34 and the fourth leading cause of death among those aged 35-44, resulting in approximately one death every twelve minutes.[71] Rates of suicide are higher among those who are non-Hispanic American Indian/Alaska Native, middle-aged adults, those who live in rural areas, and veterans and other military personal and show great geographic variation.[72,73]
- **Our recommendations**
    - The workgroup worked closely with and built from the Washington Suicide Prevention Plan released in January 2016 and the previous Bree Collaborative recommendations on integrating behavioral health into primary care released in March 2017. Recommendations are applicable to in- and out-patient care settings

[67] Hogan MF, Grumet JG. Suicide Prevention: An Emerging Priority For Health Care. *Health Aff (Millwood)*. 2016 Jun;35(6):1084-90.
[68] Cerel J, Maple M, van de Venne J, Moore M, Flaherty C, Brown M. *Exposure to Suicide in the Community: Prevalence and Correlates in One U.S. State.* Washington D.C.: Public Health Reports. 2016;131(1):100-107.
[69] Feigelman W, Cerel J, McIntosh JL, Brent D, Gutin N. Suicide exposures and bereavement among American adults: Evidence from the 2016 General Social Survey. *J Affect Disord*. 2018;227:1-6.
[70] Centers for Disease Control and Prevention. Suicide rates rising across the U.S. www.cdc.gov/media/releases/2018/p0607-suicide-prevention.html. Published June 2018. Accessed June 8, 2018.
[71] Kochanek KD, Murphy SL, Xu J, Arias E. Mortality in the United States, 2016. www.cdc.gov/nchs/data/databriefs/db293.pdf Published December 2017. Accessed August 2019.
[72] Murphy SL, Xu J, Kochanek KD, Curtin SC, Arias E.. Deaths: Final Data for 2015. www.cdc.gov/nchs/data/nvsr/nvsr66/nvsr66_06.pdf. Published June 2016. Accessed August 2019.
[73] Dwyer-Lindgren L, Bertozzi-Villa A, Stubbs RW, Morozoff C, Shirude S, Unützer J, et al. Trends and Patterns of Geographic Variation in Mortality From Substance Use Disorders and Intentional Injuries Among US Counties, 1980-2014. *JAMA*. 2018;319(10):1013-23.

including for care transitions, behavioral health providers and clinics, and for specialty care (e.g., oncology).

- **Focus Areas**
  - Identification of suicide risk
  - Assessment of suicide risk
  - Suicide risk management
  - Suicide risk treatment
  - Follow-up and support after a suicide attempt
  - Follow-up and support after a suicide death

PALLIATIVE CARE

Adopted November 2019 | Approved by the HCA March 2020

- **Read the report and recommendations here:** www.breecollaborative.org/wp-content/uploads/Palliative-Care-recommendations-FINAL-2019.pdf
- **Learn more about the workgroup here**: www.breecollaborative.org/topic-areas/current-topics/palliative-care/
    - Workgroup met from January to November 2019.
- **Background**
    - People with serious or advanced illness often experience increases in symptoms coupled with a decrease in function. Traditional life-prolonging or curative care often does not meet a person's range of needs as illness progresses or as a person nears the end of life. Fragmented care delivery and frequent transitions between care settings, unmet symptoms such as pain, and responsibilities put on family members and other caregivers create undue stress and burden on the individual.[74] Palliative care fills the gap between intensive curative care and supportive care to better meet patient need by "focus[ing] on expert assessment and management of [symptoms including] pain…assessment and support of caregiver needs, and coordination of care [attending] to the physical, functional, psychological, practical, and spiritual consequences of a serious illness."[75]
    - Provision of palliative care consistently shows improved outcomes for patients in both in- and out-patient settings.[76] Palliative care has been associated with reduction in symptom burden, higher satisfaction with care, higher referrals to hospice, and fewer days in a hospital.[77,78]
- **Our Recommendations**
    - This workgroup acknowledges the great amount of work that has gone into defining palliative care and setting standards by other organizations and has endorsed and adapted some of these for Washington State. Further, the workgroup chose to focus on the functions of palliative care rather than assign specific clinical roles to allow greater adaptability based on local resources.
    - **Focus areas**
        - Defining palliative care using the standard definition developed by the National Consensus Project including appropriateness of primary and specialty palliative care
        - Spreading awareness of palliative care

[74] Institute of Medicine. DYING IN AMERICA: IMPROVING QUALITY AND HONORING INDIVIDUAL PREFERENCES NEAR THE END OF LIFE. Washington, DC; *National Academies Press*; 2015.
[75] National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care, 4th edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018.
[76] Institute for Clinical and Economic Review. Palliative Care in the Outpatient Setting. https://icer-review.org/material/the-effectiveness-and-value-of-palliative-care-in-the-outpatient-setting/. Published April 2016. Accessed April 10, 2019.
[77] Gomes B, Calanzani N, Curiale V, McCrone P, Higginson I. Effectiveness and cost-effectiveness of home palliative care services for adults with advanced illness and their caregivers. *Sao Paulo Med J*. 2016;134(1):93-4.
[78] Hall S, Kolliakou A, Petkova H, Froggatt K, Higginson IJ. Interventions for improving palliative care for older people living in nursing care homes. Cochrane Database Syst Rev. 2011 Mar 16;(3):CD007132.

- Clinical best practice provision of palliative care that is: responsive to local cultural needs, includes advance care planning as outlined in the 2014 Bree Collaborative End-of-Life Care Report and Recommendations including appropriateness of an advance directive and Physician Orders for Life-Sustaining Treatment (POLST), and incorporates goals of care conversations into the medical record and plan of care
- Availability of palliative care through revision of benefit structure such as a per participant per month (PPPM) benefit

APPENDIX F: 2016 IMPLEMENTATION SURVEY AND ROADMAP

IMPLEMENTATION SURVEY

In 2016 Bree Collaborative staff developed a comprehensive survey to assess implementation of recommendations across care settings and health plans. The survey included 13 topics that had been approved at least six months prior to the time the survey was conducted.

See the survey tools: www.breecollaborative.org/implementation/

Staff asked key leaders from Washington hospitals, medical groups, and health plans to complete the survey, which included specific recommendations for each topic. Participation was voluntary, and responses were self-reported. A numeric scale was used to rate implementation of specific recommendations including: 0-No action taken; 1-Actively considering adoption; 2-Some/similar adoption; and 3-Full adoption.

The survey found varying degrees of adoption. Recommendations for obstetrics care, cardiology, and the Spine SCOAP program were most fully implemented. All these recommendations work with or within existing, established programs. Among hospitals and medical groups, screening and treatment for alcohol and substance use disorder showed the lowest level of adoption. Among health plans, the surgical bundles were least adopted. Within the topic-specific recommendations, the survey found trends including low adoption of patient screening and assessment tools and patient decision aides. Specific implementation scores are shown in Table 1.

Table 1: Implementation scores by topic

Topic	Hospitals	Medical Groups	Health Plans
Addiction and Dependence Treatment	1.4 (0.9-2.6)	1.4 (0.0-2.4)	1.9 (1.2-2.4)
Lumbar Fusion Surgical Bundle	1.9 (0.3-2.9)	-	0.7 (0.0-2.0)
Low-Back Pain	2.0 (1.0-3.0)	1.8 (0.5-2.8)	1.2 (0.7-1.7)
Prostate Cancer Screening	2.3 (2.0-3.0)	1.6 (0.0-2.8)	0.7 (0.0-3.0)
End-Of-Life Care	2.2 (1.7-2.6)	1.7 (0.0-2.5)	1.8 (1.0-3.0)
Avoidable Hospital Readmissions	1.6 (0.0-3.0)	2.5 (1.8-3.0)	2.7 (2.0-3.0)
Prescribing Opioids for Pain	2.5 (2.1-2.5)	1.8 (0.0-2.7)	1.7 (1.0-2.0)
Oncology Care	2.1 (1.8-2.7)	2.2 (0.0-3.0)	1.4 (0.0-3.0)
Coronary Artery Bypass Graft Surgical Bundle	2.2 (2.0-2.8)	-	0.4 (0.0-1.0)
Knee and Hip Replacement Surgical Bundle	2.3 (1.7-3.0)	-	1.0 (0.0-2.0)
Obstetric Care	2.8 (1.9-3.0)	2.8 (2.4-3.0)	2.0 (1.0-3.0)
Spine Surgical Care and Outcomes Measurement Program (SCOAP)	2.8 (2.0-3.0)	-	-
Cardiology	3.0 (3.0-3.0)	-	-

IMPLEMENTATION ROADMAP

The implementation roadmap outlines steps that provider organizations and health plans can take to implement Bree Collaborative recommendations, and strategies to overcome implementation barriers.

See the Implementation Roadmap here: www.breecollaborative.org/wp-content/uploads/Bree-Implementation-Roadmap-Final-17-04.pdf

Table 2: Top enablers and barriers affecting recommendation implementation

	Top Enablers	Top Barriers
Providers	Existing organizational improvement program for minimizing errors and waste	Lack of availability and credibility of data, and the burden of collecting it
	Business case- evidence of economic reward	Business case- no economic reward, and lack of contract partners interested in value-based purchasing
	Consensus on what constitutes quality of care	Lack of consensus on what constitutes quality of care
	Individual provider-level performance feedback	
Health Plans	Sufficient market share/volume	Insufficient market share/volume
	Contract partners interest in value-based purchasing	Burden/ease of collecting or obtaining data
	Consistency in findings across multiple measures	Business case- evidence of economic reward